Handbook for Working with Defendants and Offenders with Mental Disorders

Third Edition

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The Federal Judicial Center

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The Federal Judicial History Office develops programs relating to the history of the judicial branch and assists courts with their own judicial history programs.

The Interjudicial Affairs Office provides information about judicial improvement to judges and others from foreign countries and identifies international legal developments of importance to personnel of the federal courts.

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This Federal Judicial Center publication was undertaken in furtherance of the Center's statutory mission to develop and conduct education programs for judicial branch employees. The views expressed are those of the authors and not necessarily those of the Federal Judicial Center.

Contents

Preface iv

Introduction 1

Chapter 1: Case Management and the Individual with a Mental Disorder 3

- Introduction to Mental Disorders 3
- Introduction to Supervision Issues 11
- Major Depression 29
- Bipolar Disorders (Manic and Manic-Depressive Illness) 32
- Schizophrenia 34
- Panic Disorder 38
- Phobias 40
- Post-Traumatic Stress Disorder 42
- Obsessive-Compulsive Disorder 45
- Other Disorders of Impulse Control 46
- Paraphilias 49
- Paranoid Personality Disorder 52
- Schizoid Personality Disorder 54
- Schizotypal Personality Disorder 55
- Antisocial Personality Disorder 56
- Borderline Personality Disorder 58
- Histrionic Personality Disorder 61
- Narcissistic Personality Disorder 62
- Avoidant Personality Disorder 63
- Dependent Personality Disorder 65
- Obsessive-Compulsive Personality Disorder 66

Chapter 2: Co-occurring Disorders 69
Treatment Issues 69
Supervision Issues 70
Chapter 3: Child Molesters 72
Pedophile or Child Molester? 72
Reactions After Identification 81
Appendix A: Frequently Encountered Terminology 85
Appendix B: *DMS-IV* Classification Axes 96
Appendix C: Antipsychotic Medications 100
Appendix D: National Associations, Agencies, and Clearinghouses 101
Appendix E: Related Web Sites 103
J-Net Resource 103
Nonprofit Organizations 103
Federal Government Sites 104
Professional Organizations 104
Other 104
Appendix F: Commonly Used Abbreviations 105
Professional Degrees and Licenses 105
Diagnoses and Conditions 105
Treatment 106
Shorthand 106

Preface

The Center first published the *Handbook for Working with Defendants and Offenders with Mental Disorders* in 1994. It has revised this handbook twice since its initial publication in order to provide officers with up-to-date information on therapeutic and supervision practices, new medications, and the growing number of national mental health associations. The Center would like to thank those mental health professionals who contributed to each of the three editions. Cynthia Barry, PhD, and Glen Skoler, PhD, served as reviewers for the 1994 edition. Susan E. Holliday, MSW, LCSW-C, joined Dr. Skoler in updating the second edition in 1999. Migdalia Baerga, MSW, LCSW, and Melissa Cahill, PhD, served as the reviewers for this, the third edition. The Center also thanks the National Institute of Corrections for its financial support for the participation of Dr. Cahill, Chief Psychologist, Dallas County Community Supervision and Corrections Department in Dallas, Texas, in this project.

This *Handbook for Working with Defendants and Offenders with Mental Disorders* is a reference guide for all probation and pretrial services officers regardless of their experience supervising individuals with mental disorders. Officers with little or no experience in this area will also want to view the three-part Federal Judicial Television Network (FJTN) training program *Supervising Defendants and Offenders with Mental Disorders*. Part 1 examines the types and causes of mental disorders most often encountered by federal probation and pretrial services officers and includes a description of frequently prescribed treatments. Part 2 addresses the officer's role in identifying individuals with mental disorders and recommending conditions for their supervision. In Part 3, the series concludes with a discussion of the officer's role in referring individuals for treatment, coordinating the treatment process, and responding to supervision challenges presented by individuals with mental disorders. Each broadcast is two hours long. Videotapes of the broadcast and participant guides are available from the Center's Information Services Office.

Introduction

While intended as a reference guide for federal probation and pretrial services officers, this handbook does not provide all the information you need to work effectively with individuals with mental disorders. To enhance your ability to work with individuals with mental disorders, you should

- refer to the *Guide to Judiciary Policies and Procedures*, volume 10, chapter 11, "Mental Health Supervision," and applicable district policies for guidance on confidentiality, third-party risk, and other supervision issues related to supervising mentally disordered persons;
- refer to the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR)*[1], the authoritative source for information on clinical diagnoses, including specific diagnostic criteria for each disorder and discussions of possible alternative diagnoses for each set of symptoms;
- refer to the *2003 Physicians' Desk Reference* and the new *PDR® Drug Guide for Mental Health Professionals* which includes information on 70 common brand name psychotropic drugs, approved uses of common prescription drugs, psychological side effects of those drugs, and prescription drugs with potential for abuse.
- consult with your mental health specialist or community mental health professionals regarding case-specific characteristics and treatment strategies;
- staff cases with colleagues and management to determine the most effective supervision plan based on the resources available in your district;

1. The most recent version of this manual is the fourth edition, text revision, known as the *DSM-IV-TR*. There are relatively few changes from IV to IV-TR and they don't affect the criteria for most disorders; therefore, most professionals are still using the *DSM-IV*. We will refer to the *DSM-IV* in this manual. The *DSM-IV* defines mental disorders in terms of descriptive symptoms and behaviors. It does not generally address the causes of a psychiatric disorder.

- work with your training coordinator to develop in-service training conducted by community mental health professionals or the district's mental health specialist; and
- broaden your knowledge of mental disorders by reading journals and books, viewing videos, and attending seminars.

Chapter 1: Case Management and the Individual with a Mental Disorder

This chapter contains clinical information on selected mental disorders. It also contains general strategies for supervising all persons with mental disorders on federal pretrial and probation supervision, as well as information for supervising those with a particular mental disorder. Medical terms are defined in Appendix A.

The diagnostic criteria and associated features for the mental disorders are reprinted with permission from the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV),* the authoritative source for clinical information. Copies can be ordered at cost from the American Psychiatric Press at (800) 368-5777.

All statistical and treatment information is adapted with permission from the *Synopsis of Psychiatry*, by Harold I. Kaplan and Benjamin J. Sadock (Baltimore, Md.: Williams & Wilkins, 1991).

Supervision strategies and case-management techniques are adapted from volume 10, chapter 11 of the *Guide to Judiciary Policies and Procedures* and from information provided by experienced senior officers and mental health specialists in federal probation and pretrial services.

The Office of General Counsel of the Administrative Office of the U.S. Courts reviewed information about legal issues in this chapter.

Introduction to Mental Disorders

The *Guide to Judiciary Policies and Procedures*, volume 10, chapter 11, states that "[a]n individual is considered suffering from some form of mental disease or defect when his or her exhibited behaviors or feelings deviate so substantially from the norm as to indicate disorganized thinking, perception, mood, orientation, and memory.

Mental disease or defect can range from mildly maladaptive to profoundly psychotic and can result in

- unrealistic behavior;
- marked inability to control impulses;
- grossly impaired judgment;
- aberrant behavior;
- an inability to care for oneself or meet the demands of daily life;
- a loss of contact with reality; or
- violence to self or others."

The *Guide* also states that individuals with mental disorders constitute a relatively small percentage of the overall population under federal supervision, but their importance is disproportionate because they

- require more monitoring and supervision than other cases;
- tend to be viewed as more dangerous than other individuals;
- pose difficult management problems and must be carefully monitored, as these persons often require individualized or specialized treatment; and
- require more flexibility and patience on the part of the officer than other cases.

DSM-IV

Widely used by mental health professionals as an aid in diagnosis, the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)* defines mental disorders in terms of descriptive symptoms and behaviors. The manual does not generally address the causes of a psychiatric disorder based on any one psychological theory.

The *DSM-IV* is a standard reference in the criminal justice system, and the descriptions of mental disorders in this manual are based on it, with the following caveats to officers:

- Not all *DSM-IV* disorders are included in this handbook. The handbook omits *DSM-IV* sections on medical conditions; dementias; delirium; and cognitive, drug/alcohol, and neurological disorders, which can mimic psychological disorders such as psychosis, depression, and anxiety.

- *DSM-IV* criteria are provided to help officers identify possible mental disorders and symptoms. Diagnoses should only be made by qualified mental health professionals. This caveat is especially important in light of the fact that many symptoms (e.g., depression, anxiety, confusion, and inattention) can be seen in many different disorders. Depressive symptoms, for example, can be present in schizophrenia and delusional disorders.
- Although all five *DSM-IV* diagnostic axes are listed below, it is not unusual to see reports that only specify a mental disorder on Axis I or a personality disorder on Axis II.

The *DSM-IV* employs a classification system that consists of five axes:

- Axis I: clinical disorders, including major psychiatric disorders that may be a focus of clinical attention;
- Axis II: personality disorders and mental retardation;
- Axis III: general medical conditions that are relevant to etiology or case management;
- Axis IV: psychosocial and environmental problems; and
- Axis V: global assessment and highest level of adaptive functioning.

Psychiatrists and psychologists may use all five axes to diagnose an individual. This multiaxial system, a comprehensive or holistic approach to evaluation that considers the psychosocial and environmental problems that affect individuals, leads to an accurate diagnosis and prognosis and to effective treatment planning. Appendix B to this handbook provides an overview of the *DSM-IV* classification system, including a description of the Global Assessment of Functioning (GAF) and Social and Occupational Functioning Assessment Scale (SOFAS).

The axes that are most relevant to officers are I and II, which classify mental and personality disorders. A description of Axis IV is included, since psychosocial and environmental problems may affect the diagnosis, treatment, and prognosis of Axis I and Axis II disorders.

Axis I Disorders

Axis I disorders are the major psychiatric disorders that most people associate with mental illness. The Axis I disorders included in this handbook are

- mood disorders, including major depression and bipolar disorder;
- schizophrenia and other psychotic disorders;
- anxiety disorders, including panic disorder, phobias, and post-traumatic stress disorder, and obsessive-compulsive disorder;
- delusional disorders;
- paraphilias; and
- dissociative disorders.

Many Axis I disorders are treated with medication and therapy. Psychotropic medications include antidepressant, antimanic, anticonvulsant, antianxiety, and antipsychotic medications. Although medication and therapy are often indicated, disorders vary in their prognosis for complete recovery.

Axis II Disorders

The key to understanding Axis II personality disorders is the word *personality*. *Personality* is defined as all the emotional and behavioral traits that characterize a person in day-to-day living under ordinary conditions. These traits, which differ from individual to individual, define who we are, how we see the world, and how the world sees us.

In mentally healthy individuals, the emotional and behavioral traits that compose their personalities are relatively stable, consistent, and predictable. These traits, although dominant, are also flexible and adaptive. This flexibility allows the individual to survive stress and to function within an ever-changing environment.

In contrast, individuals with a personality disorder have traits that are inflexible and maladaptive. These traits begin in early adulthood and are present in a variety of contexts. Rather than adapting to their environment, individuals with personality disorders expect the environment to adapt to them. Unlike persons diagnosed with Axis I disorders, persons diagnosed with Axis II disorders generally do not feel anxiety or distress about their maladaptive behavior. When they feel pain and

discomfort, they rarely assume there is anything wrong with them. Rather, they think the difficulties lie outside themselves.

DSM-IV classifies personality disorders into three clusters:

- Cluster A includes the paranoid, schizoid, and schizotypal personality disorders.
- Cluster B includes the antisocial, borderline, histrionic, and narcissistic personality disorders.
- Cluster C includes the avoidant, dependent, and obsessive-compulsive personality disorders.

It should be noted that this clustering system, although useful in some research and educational situations, has serious limitations and has not been consistently validated. According to *DSM-IV*, many patients exhibit traits that meet the diagnostic criteria for more than one personality disorder.

Individuals with personality disorders often deny their problems, refuse psychiatric help, or resist treatment. The pervasive and inappropriate character traits associated with personality disorders generally are not treated with medication. Therapy is the treatment of choice for personality disorders; however, certain personality disorders do not have a good prognosis for treatment, since patients are resistant to changing their personalities. Occasionally, medication may be prescribed to treat other or associated psychiatric symptoms, such as depression or anxiety. Psychiatric and treatment information for personality disorders is given later in this chapter.

Mental Retardation

Axis II is also where mental retardation is coded. Mental retardation is a disorder in which a person has below average intelligence (an IQ of 70 or below), with an onset before age 18, and impairments in everyday functioning. Mental retardation can be characterized as mild, moderate, severe, or profound. The following traits are often seen in individuals with mental retardation:

- limited vocabulary;
- difficulty understanding and answering questions;
- mimic responses;
- easily led by others (especially those in authority);

- naïvely eager to please;
- displays of childlike behavior;
- lack of awareness of social norms and appropriate behavior; and
- difficulty staying focused and easily distracted.

In community corrections, we most often see individuals with mild mental retardation. Individuals with mild mental retardation can develop social and communication skills, can usually obtain academic skills up to a sixth-grade level, and may be self-supporting. Individuals with mild retardation will usually need help when under stress.

Axis IV: Psychosocial and Environmental Problems

A psychosocial or environmental problem may be a negative life event, an environmental difficulty or deficiency, family stress or other interpersonal stress, lack of adequate social support or personal resources, or other problems relating to the context in which a person's difficulties have developed. So-called positive stressors, such as job promotion, are listed on a clinician's report only if they constitute or lead to a problem, as when a person has difficulty adapting to the new situation. In addition to playing a role in the initiation or exacerbation of a mental disorder, psychosocial problems may also develop as a consequence of a person's psychopathology or may constitute problems that should be considered in the overall management plan.

For convenience, the problems are grouped together in the following categories:

- **problems with the primary support group**—e.g., death of a family member; health problems in the family; disruption of the family by separation, divorce, or estrangement; removal from the home; remarriage of a parent; sexual or physical abuse; parental overprotection; neglect of a child; inadequate discipline; discord with siblings; birth of a sibling;
- **problems related to the social environment**—e.g., death or loss of a friend, inadequate social support, living alone, difficulty with acculturation, discrimination, adjustment to life-cycle transition (such as retirement);
- **educational problems**—e.g., illiteracy, academic problems, discord with teachers or classmates, inadequate school environment;

- **occupational problems**—e.g., homelessness, inadequate housing, unsafe neighborhood, discord with neighbors or a landlord;
- **economic problems**—e.g., extreme poverty, inadequate finances, insufficient welfare support;
- **problems related to access to health care services**—e.g., inadequate health care services, lack of transportation to health care facilities, inadequate health insurance;
- **problems related to interaction with the legal system or to crime**—e.g., arrest, incarceration, litigation, victimization (robbery, assault, etc.); and
- **other psychosocial and environmental problems**—e.g., exposure to disaster or war; discord with non-family caregivers, such as counselors, social workers, or physicians; lack of social services.

Multiple Diagnoses

An individual can be diagnosed with

- more than one Axis I disorder (e.g., both schizophrenia and major depression) or Axis II disorder; or
- both an Axis I disorder and an Axis II disorder (e.g., major depression and borderline personality disorder).

When multiple disorders exist, all applicable diagnoses should be listed in the mental health professional's report. Although many mental health professionals list what they consider to be the primary diagnosis first, that is not always the case. Therefore, don't assume that the first diagnosis listed is the primary diagnosis.

Recently, mental health professionals have been using the term *co-occurring disorders* to refer to individuals with both a substance abuse or dependence disorder and another Axis I disorder, and the term *dual diagnosis* to refer to an individual diagnosed with both mental retardation and an Axis I disorder.

Medical Notations

There are three notations you may see on medical reports dealing with multiple diagnoses:

1. R/O means "rule out." For example, you may read "Axis I major depressive episode R/O bipolar disorder." This means that the individual was exhibiting symptoms associated with both major depression and bipolar disorder. Upon evaluation, the mental health treatment provider determined the individual's behavior probably met *DSM-IV* criteria for a depressive disorder and that bipolar disorder still needed to be ruled out.
2. Personality Disorder NOS (not otherwise specified). You may see this on an evaluation when an individual is exhibiting symptoms of one or several personality disorders, but does not meet the diagnostic criteria for a specific personality disorder. The NOS category can also be used for Axis I disorders.
3. Provisional. A mental health professional may put this after a diagnosis, indicating that he or she believes the person meets criteria for the diagnosis, but is not certain.

Brain Damage

Brain damage can occur from very traumatic events (e.g., getting shot) or less traumatic, repeated events (e.g., multiple physical fights) and can occur with or without a loss of consciousness. Brain damage results in a host of different symptoms that may look like an Axis I or Axis II disorder. Men are twice as likely as women to sustain brain damage, and men age 14–24 are at highest risk.

The most typical causes of brain damage are car accidents (where injury can occur even without a loss of consciousness), anoxia (loss of oxygen to the brain), aneurysm (weakened blood vessels bursting and causing bleeding in the brain), brain tumor, stroke or cardiovascular accident, epilepsy, infectious diseases, and substance abuse.

Symptoms which suggest brain damage include persistent headaches, unusual fatigue, poor concentration, memory deficits, mood swings or frequent irritability, poor judgment, difficulty making decisions, poor organization or planning skills, impulsivity, difficulty performing multiple tasks, and problems with strength, balance, or coordination.

Introduction to Supervision Issues

Supervising a person with a mental disorder can pose many challenges for the probation and pretrial services officer. To ensure successful supervision, the officer must have a thorough understanding of the case prior to supervision. The officer should take an active role in developing prerelease plans and coordinating mental health care or treatment services. Officers who work with individuals with mental disorders must be patient and flexible, must have knowledge of mental disorders, and must develop the skills necessary to work effectively with these individuals.

Because of the unique problems and needs associated with each individual with a mental disorder, supervision strategies vary from case to case. This section reviews issues common to the majority of cases. The remaining sections in Chapter 1 identify treatment and supervision issues specific to selected mental disorders.

Treatment Issues

According to the *Guide to Judiciary Policies and Procedures*, an officer should consider recommending professional evaluation when the individual

- exhibits behavior that is bizarre or dangerous to himself or herself or to others;
- has a history of psychiatric problems as documented in hospital records and prior criminal record, or a history of suicidal gestures;
- verbalizes suicidal ideation or has feelings of depression or other symptoms of mental disorder (e.g., hallucinations, delusions, or manic episodes); or
- warrants evaluation because of the nature of the offenses (e.g., making threats to public officials).

The officer should be alert to possible significant changes in the person's behavior or appearance and to all significant stressors that could result in mental deterioration, including family difficulties, employment changes, or recent losses that are due to events like divorce or death.

Mental health treatment should begin with an assessment, highlighting the risk for violence or suicide, which is common in some disorders and may be evident during pretrial release and probation supervision. Treatment may consist of therapy, medication, or both, provided by professional mental health treatment practitioners.

Therapy. A psychiatrist, psychologist, or social worker can provide therapy. Whenever possible, the officer should refer an individual with a mental disorder to a therapist experienced in treating similarly diagnosed patients or to a clinic that provides treatment for specific disorders. Only psychiatrists, other medical doctors, and qualified practitioners, such as qualified nurse practitioners with prescriptive authority, who meet their state regulatory boards' standards can prescribe medications. Psychotropic medications should be prescribed in conjunction with a treatment regimen. The individual should be considered to be in treatment as long as he or she is taking medication or participating in therapy.

There are numerous public and private mental health services. Most counties have community mental health centers to serve a range of patients at all socioeconomic levels. Agencies vary in

- types of disorders treated;
- available forms of treatment;
- intake procedures;
- willingness to accept a person who is mandated to attend treatment but is unmotivated or has a history of violence;
- staff credentials;
- fees and funding sources; and
- location and hours of operation.

The accurate matching of treatment agency or provider to individual increases the chance for a successful adjustment. Officers should be knowledgeable about local treatment resources and should carefully evaluate programs before referring individuals for treatment. In addition, officers should consider agency policies and procedures that may affect their ability to monitor compliance with treatment. Officers should also determine the agency's ability to provide comprehensive programs and services (including inpatient, outpatient, individual, family and group services, and medication) as well as its staff's sensitivity to cultural differences.

The particular treatment approach is the sole decision of the mental health provider. At the outset of treatment, the officer's role should be clarified with the clinician and explained to the individual. The officer may act as treatment liaison, judicial system representative, or monitor and enforcer of conditions. As a liaison between the client and the treatment provider (particularly in cases of conditional release), the officer

stresses to the client the need to communicate fully with the treatment provider, brings pertinent information about the family situation and environment to the attention of the treatment provider, and alerts the treatment provider to adverse side effects of medication. As the representative of the court or the U.S. Parole Commission, the officer is responsible for monitoring and enforcing compliance with any treatment conditions and medication regimen. The officer needs to maintain ongoing contact with the treatment provider and to ask the provider to immediately report to him or her any instance of the individual's failing to comply with treatment.

Medication. Officers should familiarize themselves with the intended effects and side effects of medications taken by individuals with mental disorders. Side effects can range from mild (dry mouth, drowsiness) to severe (low blood pressure, involuntary muscle spasms). Some medications cause anxiety or disorientation.

Antipsychotic medication, which must be taken continually over a period of time to effectively control delusions and hallucinations, can cause side effects, such as slurred speech, drowsiness, or constipation, that lessen over time as the body adapts to the medication. Other side effects?such as changes in white blood cell count, low blood pressure, facial muscle spasms, and involuntary muscle movement?are more severe and pose greater risk. Some of these side effects may become permanent if not detected early. There are fewer and less severe side effects with the newer antipsychotic medications, such as Zyprexa and Risperdal. See Appendix C for a list of commonly prescribed antipsychotic medications.

Individuals experiencing side effects may refuse to take their medication. They may also become noncompliant because they are experiencing symptoms of their disorder that make them think they don't need the medication or that may prevent them from remembering to take their medication.

Officers should remind these individuals that the medication may not be effective unless taken as prescribed and encourage them to discuss the side effects with their treatment providers.

Ask the prescribing physician about the interaction of the medication and alcohol. Some medications, such as those that combat anxiety, increase the effects of alcohol. Share with the physician information regarding the individual's alcohol use or abuse and warn the individual about the danger of mixing alcohol and medication.

If you suspect that an individual is not taking prescribed medication, consider asking the physician to take blood tests to help monitor medication compliance. You may request tests but may not demand them without a special condition of supervision. Advise the individual that he or she is not required to provide blood samples but that a refusal to do so could be reported to the court and the conditions of supervision could be modified to specifically require testing.

Release of confidential information. Obtain consent from the individual so that you may receive information directly from mental health evaluators or treatment providers regarding the individual's compliance with all requirements. Have the individual sign the United States Probation System Authorization to Release Confidential Information – Mental Health Treatment Programs (Probation Form 11I) or, in the case of pretrial services, United States Pretrial Services System Authorization to Release Confidential Information – Mental Health Treatment Programs (Pretrial Services Form 6D).

In co-occurring cases, have the individual complete Probation Form 11B, an authorization to release confidential drug abuse treatment information, in addition to Probation Form 11I.

Files of parolees with mental disorders that are controlled by the Unites States Parole Commission can be requested from the regional office under the Freedom of Information Act and the Privacy Act. Disclosure of such information to social services agencies and treatment providers should be discussed in advance with the case analyst in the regional office.

Like other probation and pretrial services records, files on individuals with mental disorders are confidential and are under the court's jurisdiction. The court is exempt from both the Freedom of Information Act and the Privacy Act, pursuant to 5 U.S.C. § 552. Disclosure of the contents of the files is the prerogative of the court and occurs only when required by statute, rule, guideline, established court policy, or specific direction of the court. Therefore, information disclosed to social services agencies and treatment providers must have the prior approval of the court. The law does not require the consent of individuals. However, since some officers are licensed mental health practitioners and all licensed practitioners are required by professional standards and ethics to have clients sign release forms, those officers who are licensed may wish to secure a client's permission before disclosing information. (See *Guide to Judiciary Policies and Procedures*, vol. 10, chap. 2/A: Confidentiality, Non-disclosure and Exclusions Issues; chap. 4/D: Releasing File Information.)

Funding sources. Officers are responsible for investigating payment options and for determining whether the person can contribute to the cost of treatment. In some cases, the person may be entitled to services from community mental health centers and veterans' hospitals. If not, the government or the individual may be required to subsidize treatment (18 U.S.C. § 3672). The director of the Administrative Office of the United States Courts (AO) has the authority to contract for mental health services. The AO's probation budget has funds allocated for mental health treatment, but recommends copayment for contract mental health services. (See *Guide to* Judiciary Policies and Procedures, vol. 10, chap. 12/A: Purpose and Approach.)

Individual-based payment can come from health insurance, Social Security Income (SSI), employment assistance programs, or cash. Many persons with chronic mental disorders have been maintained on SSI, a type of disability income. The application process is long and complicated. Persons with mental disorders may need assistance when applying for SSI benefits. Officers can provide this assistance or refer the individual to local community resources, such as case-management services offered by United Way agencies.

An individual with a mental disorder whose SSI disability income payments have been suspended because of incarceration may have these benefits reinstated by showing his or her release forms to the local Social Security office. Individuals whose SSI disability income payments have been terminated, for whatever reason, must reapply for the payments to be reinstated.

Treatment Compliance

Mental health treatment is often court ordered or required by the officer as part of supervision. Yet, many individuals resist treatment, fail to attend treatment sessions regularly or at all, or drop out of treatment prematurely. Some may see a psychiatrist for medication and report that they are in treatment but may not be participating in therapy. Others may report that they have been in treatment for several months, when in fact they have attended only a few sessions.

In addition to personal contacts with the treatment provider to solicit essential information, obtain written documentation about treatment through the use of a monthly treatment report (Probation Form 46), which should include information such as

- dates of appointments (kept and missed);
- type, dosage, and administration of medications;

- compliance with the medication regimen; and
- treatment progress (or lack of progress).

Ensure that the mental health professional knows if you are to be contacted about missed appointments or lack of treatment and evaluation compliance. Cases receiving contracted treatment services can have these requirements spelled out in the Treatment Program Plan (Probation Form 45).

Treatment Termination

Treatment termination should be a joint decision by the officer, the treatment provider, and the individual. Each should feel confident that the individual is symptom-free and has benefited as much as possible from the therapeutic process.

Occasionally, a mental health treatment provider will recommend terminating treatment because the provider feels that the individual is not participating or cooperating in therapy or that the individual has progressed as far as possible. When a treatment provider recommends terminating treatment, the officer should determine the reason and request a written report. Submit the report to the court if district policy requires you to do so. If you are concerned or disagree with the provider about terminating treatment, discuss the case with the district's mental health specialist or your chief or supervisor, or seek the opinion of another treatment provider.

Treatment should not be terminated if you believe any of the following to be true:

- The individual is currently dangerous to himself or herself or to others, potentially suicidal, noncompliant with the medication regime, or unable to care for himself or herself.
- The individual's condition may in the future deteriorate or the individual may become dangerous without treatment. Even if the individual is making little or no progress, continued treatment enables the provider to monitor his or her mental state.
- The individual continues to exhibit symptoms of a disorder. If necessary, refer the individual to another mental health professional.

Because persons with mental disorders are prone to relapse, many mental health specialists recommend that the treatment condition not be removed when treatment is terminated. The standard mental health treatment condition is sufficiently broad to permit treatment termination without the officer having to ask the court to remove the

treatment condition or having to ask the court to reinstate the condition if the person has a relapse. When termination occurs, the court should be informed that the person is no longer in treatment and that the officer will monitor his or her behavior for signs of relapse.

Note: Follow all applicable policies regarding the imposition, modification, and removal of special conditions of release or supervision.

Responding to Crisis Situations

A crisis situation is any situation that presents an imminent risk to an individual or to others, and demands immediate intervention by the officer. Some examples of crisis situations are threats of suicide, physical assaults, and major psychotic episodes.

First and foremost, officers are generally not trained nor authorized to physically intervene in crisis situations. In order to respond effectively in a crisis, the officer should have a prearranged plan of action that includes having on hand emergency telephone numbers for security, the primary therapist, the crisis or mental health center, local law enforcement, and family members.

General crisis situations. According to the *Guide to Judiciary Policies and Procedures*, vol. 10, chap. 11/D, the officer's role in any crisis is to

- assess the nature and degree of danger presented by the situation (e.g., whether the situation is life threatening, weapons are involved, or others besides the individual are at risk);
- determine the extent of direct intervention necessary;
- immediately notify the treatment provider, when applicable;
- immediately notify any third party at risk;
- be sensitive to personal safety and security;
- notify necessary emergency advocates (e.g., hot lines); and
- follow through until the crisis is resolved.

Disclosure in crisis situations. Disclosure of confidential information in crisis situations is generally governed by the same rules that govern other disclosures, but the application of those rules may be somewhat different. By definition, crisis situations present risks to the individual or third parties, and the officer has an

obligation to do what is necessary to reduce that risk. Insofar as the necessary actions involve disclosure of otherwise confidential information, the officer is authorized to disclose, without prior approval by the court (unless the court in the officer's district has determined otherwise), as much information as the officer believes is necessary to reduce the risk. Disclosure may be made to parties at risk and to entities, such as law enforcement agencies, that may be able to intervene to prevent the harm. It would be good practice to advise the court of such disclosures as soon as you are able to do so. (See the discussion of third-party risk on page 18.)

Suicidal crisis situations. The *Guide* states, "The probation/pretrial services officer, in assessing suicide risk in the individual, should be aware that suicidal statements must always be taken seriously . . . and must respond promptly to any indication that the individual may be suicidal" (vol. 10, chap. 11/A). Evaluate the risk posed by any suicidal threats and gestures.

When an individual makes a suicidal threat, immediately ask questions about the suicide plan—ask when, where, and how the individual will execute the plan. Previous suicide attempts and definitiveness of a suicide plan indicate a high risk of suicide. Keep the person talking. If you have reason to believe an individual is imminently suicidal, attempt to secure his or her safety. Call the mental health treatment provider and discuss admitting the person to a hospital. Use collateral contacts, such as family, friends, or trained professionals on a suicide hotline such as 800-SUICIDE (800-784-2433), to persuade the person to go to the treatment provider or hospital.

Transporting the individual to a treatment facility yourself is too risky because the individual can open the car doors. Also, the person may require restraint. (Similarly, suggesting that a friend or family member transport the individual presents a risk.) Therefore, consider requesting police assistance to transport a suicidal individual to a hospital emergency room or an emergency psychiatric facility. In many states it is the responsibility of law enforcement officers to do so.

When talking with suicidal individuals, there are several things you can do:

- Tell the person that you are concerned about his or her safety.
- Don't hesitate to use the word "suicide." This will not put the idea into the person's head.
- Don't sound shocked or defensive about what the person says, or shame or engage the person in philosophical or theological debate about the morality of suicide.

- Be wary if the person says the crisis is over; this may indicate that he or she has made the decision to follow through with the suicide.
- Insist that the person have an immediate intake interview at the local community mental health center, which may have a walk-in clinic or an emergency services unit.
- Give the person the telephone number of a local suicide hotline.
- If the person has a treatment provider, make the provider aware of the concern.
- If the person does not have a treatment provider, initiate a referral for a mental health evaluation.

Should a suicide occur record the event and all efforts made to assist an individual prior to the suicide in your chronological records.

Suicides, while rare, have occurred even though the officer did everything that was expected of him or her. A suicide can cause a variety of troubling feelings for the officer. Should someone on your caseload commit suicide you may want to seek out a supervisor or other officers to talk with about the suicide.

Psychotic episodes. Psychosis is characteristic of a number of mental disorders, including schizophrenia and severe mood disorders. During a psychotic episode, the person incorrectly evaluates the accuracy of his or her perceptions, thoughts, and moods, and makes incorrect inferences about external reality. The ability to think, respond emotionally, remember, communicate, interpret reality, and behave appropriately is impaired. The person with a mental disorder may deteriorate into a psychotic state for a variety of reasons, for instance, by failing to take medication or experiencing extreme stress or anxiety.

Research indicates that when persons with mental disorders are experiencing active psychotic symptoms, such as delusions and hallucinations, their risk of violence increases. Obtain immediate evaluation or treatment for an individual experiencing a psychotic episode. Arrange for transportation to a local hospital emergency room, community mental health center, or emergency psychiatric facility, and contact the treatment provider.

Third-party risk. According to the *Guide to Judiciary Policies and Procedures*, vol. 10, chap. 11/D, the officer who works with persons with mental disorders has a responsibility not only to protect them from themselves but also to protect the community at large. At no time should an officer lose sight of this responsibility to

protect the community. When the officer senses the prospect of harm, he or she has a duty to warn the parties at risk. Failure to perform this duty may result in civil liability. However, the officer has no authority to disclose confidential information unless such disclosure is necessary to prevent harm to the individual or to others. Even then, the officer has to adhere strictly to established judiciary policies and procedures.

Chapter 4 of the *Probation Manual* and *Code of Federal Regulations*, Title 28, section 2.37(a)–(b) provide guidelines for third-party risk and information on disclosure policy. Before taking action after determining possible third-party risk, the officer should bring the matter to the attention of, and seek consultation with, his or her supervisor or the chief probation officer. The reasons for notification should be documented in the case files.

Violence and Individuals with Mental Disorders

Many people believe that people with mental disorders are more prone to violence and dangerous behavior than the average person; however, research does not substantiate this belief. Studies suggest that violent acts committed by individuals with major mental disorders account for at most 3% of the violence in American society.

Some mental disorders have features that are clearly associated with violent behavior toward the self or others (e.g., suicidal behavior, self-mutilation, psychotic episodes, and persecutory delusions). But violent behavior by persons with mental disorders results from the interaction of diverse personal, situational, and clinical factors; simply being diagnosed with a mental disorder does not indicate an individual's predisposition to violence.

The MacArthur Research Network on Mental Health and the Law at the University of Virginia designed the MacArthur Violence Risk Assessment Study as a supplement to its ongoing work in this area. Among the conclusions from this study are the following:

> The prevalence of violence among people who have been discharged from a hospital and who do not have symptoms of substance abuse is about the same as the prevalence of violence among other people living in their communities who do not have symptoms of substance abuse.

> The prevalence of violence is higher among people—discharged psychiatric patients or non-patients—who have symptoms of substance abuse. People who have been discharged from a psychiatric hospital are more likely than other people living in their communities to have symptoms of substance abuse.
>
> The prevalence of violence among people who have been discharged from a psychiatric hospital and who have symptoms of substance abuse is significantly higher than the prevalence of violence among other people living in their communities who have symptoms of substance abuse, for the first several months after discharge.
>
> Violence committed by people discharged from a hospital is very similar to violence committed by other people living in their communities in terms of type (i.e., hitting), target (i.e., family members), and location (i.e., at home).[2]

Nevertheless, this unpredictability warrants precautionary measures on the officer's part. The only death of a federal probation officer while on duty occurred at the hands of an individual with a mental disorder. To distinguish dangerous individuals from the less dangerous, the officer should carefully consider if any of the following characteristics are present:

- past or present substance abuse, including alcohol abuse;
- history of violence or threats of violence;
- past involuntary psychiatric commitments;
- persecutory delusions;
- acute psychotic episode(s);
- history of borderline, antisocial, or paranoid personality disorder;
- history of medication noncompliance;
- history of suicidal ideation or gestures;
- history of self-mutilation;

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2. MacArthur Research Network on Mandated Community Treatment, "The MacArthur Community Violence Study," http://www.macarthur.virginia.edu/violence.html. (accessed August 26, 2003). For more information on the MacArthur Violence Risk Assessment Study, see H. Steadman et al., "Violence by People Discharged from Acute Psychiatric Inpatient Facilities and by Others in the Same Neighborhoods." *Archives of General Psychiatry*, 55 (1998): 393–401.

- possession and knowledge of, or interest in, firearms, explosives, or other weaponry;
- uncontrolled displays of hostility toward authority figures; and
- hypersensitivity to the contacts and professional involvement of family members, friends, or significant others with the officer.

Conditional Release Cases[3]

Conditional release, unlike probation, parole, and supervised release, is a civil, not criminal, form of supervision. Section 701 of the Federal Courts Administration Act of 1992 authorized probation and pretrial services officers to supervise persons conditionally released under the provisions of 18 U.S.C. §§ 4243 (Hospitalization of a Person Not Found Guilty by Reason of Insanity) and 4246 (Hospitalization of a Person Found Guilty and Due for Release but Suffering from a Mental Disease or Defect).

Discretionary conditions of conditionally released persons must be measured against the following considerations established by 18 U.S.C. §§ 4243 and 4246:

> Individuals are released under a prescribed regimen of medical, psychiatric, or psychological care or treatment.
>
> Release of individuals will not create a substantial risk of bodily injury to another person or serious damage to property of another.

Standard conditions designed routinely for probation, parole, and supervised release cases do not apply, and should not be enforced in conditional release cases unless they are specifically imposed by the court as part of the regimen of treatment and care authorized by 18 U.S.C. §§ 4243 and 4246. Enforcement of a regimen of care or treatment that is not medically or psychologically justified has been held to constitute a denial of due process.[4]

A psychiatrist, psychologist, or medical expert at the Federal Bureau of Prisons (BOP) recommends the conditional releasee's regimen of care and treatment while at a BOP

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3. From Appendix 3: The Supervision of Federal Offenders, Monograph 109. Office of Probation and Pretrial Services. Administrative Office of the U.S. Courts. 2003.

facility. A treatment team reviews the status of a committed person on a regular basis. When the team believes that a committed person should be considered for a conditional release, a risk assessment is performed. A panel of psychiatrists or psychologists conducts the assessment in some institutions, and in other institutions a forensic psychologist conducts it. Ultimately, the risk assessment renders an opinion as to what should be addressed in the conditions of release.

In most cases, the social work staff at BOP medical centers is primarily involved in the discharge planning for persons granted conditional release. The primary BOP facilities that house persons eligible for conditional release are Federal Medical Center, Butner, North Carolina; Federal Medical Center, Carswell Air Force Base, Fort Worth, Texas; Federal Medical Center, Rochester, Minnesota; and Medical Center for Federal Prisoners, Springfield, Missouri. The social work staff, relying on the recommendations in the risk assessment, makes referrals to various community agencies, such as state hospitals, community mental health agencies, and residential care providers. The social work staff routinely consults and collaborates with probation officers in the discharge planning process.

Once an appropriate discharge plan is formed, the court is petitioned for a conditional release. The recommendations for specified conditions of release are set forth by the BOP staff, primarily social workers, with input from the probation office, and ordered by the court. For 18 U.S.C. § 4243 cases, the court of jurisdiction is the court where the case originated. For 18 U.S.C. § 4246 cases, the court of jurisdiction is the court nearest to the institutional facility where the person is housed.

The following are examples of the conditions of release that have been imposed on conditionally released individuals in various districts nationwide.

> Mr./Ms. X shall be and remain under the supervision of the United States Probation Office until further orders of this court and he/she shall comply with all of the specified conditions herein set forth:
>
> 1. Mr./Ms. X shall reside with _____ at _____ telephone number: _____. His/her supervising United States probation officer must approve any change in Mr./Ms. X's residence.
> 2. Mr./Ms. X shall maintain active participation in a regimen of outpatient mental health care administered by _____ located at _____. Any noncompliance with his/her treatment regimen

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4. United States v. Woods, 995 F.2d 894 (9th Cir. 1993).

shall be reported to the supervising United States probation officer immediately.

3. Mr./Ms. X shall continue to take such medication, including injectable units, as shall be prescribed by the medical/mental health treatment provider. Any noncompliance with his/her treatment regimen shall be immediately reported to the supervising United States probation officer.

4. Mr./Ms. X shall not associate with individuals consuming alcoholic beverages, shall not frequent business establishments whose primary product to the consumer is alcoholic beverages or places where controlled substances are illegally sold, used, distributed, or administered.

5. Mr./Ms. X shall refrain from the use of alcohol and illegal possession/use of drugs, and shall submit to urinalyses or other forms of testing to ensure compliance. It is further ordered that Mr./Ms. X shall submit to alcohol/drug aftercare treatment, on an outpatient or inpatient basis, if directed by the United States Probation Office. Mr./Ms. X shall abide by the rules of any program and shall remain in treatment until satisfactorily discharged with the approval of the United States Probation Office.

6. By accepting release pursuant to this order, Mr./Ms. X waives his/her right to confidentiality regarding his/her mental health treatment in order to allow unrestricted sharing of information with his/her supervising United States probation officer, who will assist in evaluating his/her ongoing appropriateness for community placement.

7. Mr./Ms. X shall not have in his/her possession at any time real or imitation firearms, destructive devices, or other deadly weapons. He/she shall submit to a warrantless search on request of his/her probation officer or any law enforcement officer of his/her property for the purpose of determining compliance with this order.

8. Mr./Ms. X shall not commit a federal, state, or local crime, and must immediately notify his/her United States probation officer if he/she is arrested or questioned by any law enforcement officer. He/she shall not associate with any person convicted of a felony unless granted permission to do so from his/her United States probation officer.

9. Mr./Ms. X is prohibited from operating, possessing, or purchasing a motor vehicle without written permission from his/her United States probation officer. He/she may not travel outside the “local area” as that area specifically is defined by the United States probation officer, except with the prior approval of that officer.

10. Mr./Ms. X must meet his/her financial obligations and maintain employment or participate in a vocational training program unless excused by his/her probation officer.
11. At the recommendation of a mental health treatment provider, Mr./Ms. X shall voluntarily admit himself/herself for inpatient mental health treatment. Should Mr./Ms. X refuse to do so and he/she presents a risk to the community, involuntary state civil commitment procedures should be pursued.
12. Mr./Ms. X shall agree to undergo serum blood level screening as directed by the treating physician, to ensure that a therapeutic level of medication is maintained.
13. Mr./Ms. X shall reside for a period of _____ months in a community corrections center, halfway house, or similar residential facility and shall observe all the rules of that facility.
14. Mr./Ms. X shall report to the probation officer as directed by the court or the probation officer, shall submit a truthful and complete written report within the first five days of each month, and shall follow the instructions of the probation officer.

Supervision Strategies

In general, all mental health cases require the following supervision strategies:

- Schedule the initial contact with a person with a mental disorder in the office because the individual may view home visits as threatening.
- Review all psychiatric documentation and other relevant medical documentation pertaining to the person.
- Assess the degree of general danger and third-party risk that the individual poses to himself or herself or to others. Note any history of dangerous behavior. Review the supervision plan with your supervisor and alert the supervisor to any special issues associated with the case.
- Identify areas in which the person may need assistance (e.g., obtaining medical assistance, disability income, housing, or vocational training).
- Have the individual sign release of confidential information forms.
- Take several photographs of the individual for the record file.

- Work with the mental health treatment provider to monitor the individual's compliance with the medication regime and to assess his/her therapeutic progress.
- Familiarize yourself with the individual's psychotropic medication so that you can talk with him or her about the medication regime and encourage him or her to take the medication as prescribed.
- Be alert to drug and alcohol abuse relapses associated with co-occurring cases.
- Coordinate treatment services. Share information with the providers as needed and in accordance with confidentiality regulations and statutes.
- Schedule contacts with the individual based on the severity of the mental disorder, the state of his or her physical health, and occupational and social circumstances.
- Clearly establish and explain the limits of acceptable and unacceptable behavior. Explain the consequences of noncompliance with the conditions of supervision.
- Identify the individual's support system (family, friends, employers, and others) and make frequent contact with these individuals.

  Note: Officers should not disclose any more pretrial, presentence, or supervision information than necessary to obtain requested information from collateral contacts. Although officers may say that a person is under presentence investigation or supervision, details of the offense and of supervision should not be disclosed unless absolutely necessary to elicit information. Refer to the *Guide to Judiciary Policies and Procedures* for additional guidance on confidentiality and investigation techniques.

  Under no circumstances should drug aftercare information be disclosed to collateral contacts. Release of such information could subject the officer to criminal penalties.
- Prepare crisis intervention plans for handling suicide threats or attempts, psychotic episodes, assault threats, and other crises that may arise as a result of the individual's mental disorder. Officers may want to consult with local crisis screening centers or crisis intervention teams in preparing these plans.

Build rapport with the individual and work to maximize the individual's motivation to comply with special conditions and treatment requirements. Work to alleviate fears and misconceptions about mental health treatment. Talk openly about the need for treatment. Address the issue of medication and its side effects. Stress the importance

of the individual's not stopping treatment without first consulting the treating physician or nurse practitioner with prescriptive authority.

The person's mental disorder and personal circumstances determine additional supervision strategies. In general, more time and attention must be spent on individuals with severe disorders or with suicidal tendencies. For example, an individual suffering from paranoid schizophrenia who fails to take medication regularly and who has no steady residence or source of income requires intensive supervision, including frequent collateral contact with the health treatment provider. In contrast, an individual with major depression who is stabilized on medication and participating in therapy and who has a supportive family and a stable job requires less frequent contact. Refer to the remaining sections of chapter 1 of this handbook for information on supervision issues unique to specific mental disorders.

Note: All supervision strategies an officer uses must be in accordance with district policy.

Treatment Conditions

Wording. Carefully word mental health treatment conditions. Many mental health specialists find it advantageous to phrase treatment conditions in a manner that provides flexibility during supervision. However, lack of specificity may make a condition difficult to enforce. The individual may claim that the condition does not give the officer authority to order a particular activity. In general, the greater the deprivation of liberty the officer's directive entails, the greater the likelihood the individual will challenge the authority of the officer to order the activity. As a general rule, officers should request specificity in mental health conditions as soon as the need for a highly restrictive form of treatment is anticipated.

For example, if you are using the general treatment condition "the individual shall participate in psychiatric services or mental health counseling as approved by the U.S. Probation Office" and an individual exhibits suicidal or psychotic behavior that requires hospitalization, order such treatment only on an emergency basis. Since hospitalization or any inpatient care results in a significant deprivation of liberty, ask

the court as soon as possible for a modification of the condition to specify inpatient care.[5]

Recommended mental health-related special conditions. Below are listed some mental health special conditions for illustrative purposes.

- Mr./Ms. X shall participate in a mental health program for evaluation and/or treatment under the guidance and supervision of the United States Probation Office. The defendant shall remain in treatment until satisfactorily discharged with the approval of the United States Probation Office.
- Mr./Ms. X shall comply with his/her prescribed medication regimen and shall contribute to the cost of any prescribed psychotropic medications via copayment or full payment based upon the defendant's ability to pay or the availability of third-party payment.
- Mr./Ms. X shall participate in a mental health treatment program to include treatment for gambling, as approved by the United States Probation Office. The defendant shall contribute to the cost of services rendered or any prescribed psychotropic medications via copayment or full payment based upon the defendant's ability to pay and/or the availability of third-party payment. The defendant is prohibited from engaging in any gambling activity, legal or illegal, or from travel to any casino-based geographical location.
- Mr./Ms. X shall submit to evaluation or treatment in an approved domestic violence prevention treatment program under the guidance and supervision of the United States Probation Office. The defendant shall remain in treatment until satisfactorily discharged by the program and with the approval of the U.S. Probation Office. The defendant shall contribute to the cost of treatment services rendered or any prescribed psychotropic medications via copayment or full payment based upon the defendant's ability to pay and/or the availability of third-party payment. The defendant shall have no direct or indirect contact via telephone, face-to-face encounters or, written correspondence, or through third-party means, with _____(name of victim).

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5. Joseph L. Hendrickson, in a *News and Views* article dated July 17, 2002, notes that any treatment condition that contains the wording "as approved by the U.S. Probation Office or Pretrial Services Office" stands a better chance of being upheld if challenged than does a condition with the wording "as approved by the U.S. Probation or Pretrial Services Officer." Occasionally conditions with the latter wording have been stricken when challenged on the basis that there was an improper delegation of judicial functions to an officer.

Officer Safety

Officers should be particularly concerned about individuals with mental disorders who are perceived to be dangerous. Personal safety must be the first priority for officers. The following are some general safety considerations.

- Be aware of the status of the person's mental health at all times. Pay special attention to medication compliance. Communicate regularly with the treatment provider and collateral contacts.
- Refrain from confronting or provoking the individual unnecessarily.
- Maintain a safe physical distance from the individual.
- Do not tower over the person or stare at him or her. Both you and the individual should sit, if possible, during interviews and home contacts.
- Identify and stay close to an accessible exit while meeting with an individual with a mental disorder.
- Depending on the current state of the individual's mental health and risk of dangerousness, consider taking another officer with you on home contacts. Notify the individual ahead of time of any home contact at which another person will be present.
- Alert another officer or support staff of the times and places of your contacts with individuals with mental disorders, particularly those with histories of violence or medication noncompliance. Establish a method of soliciting assistance when in the field.
- Never let an individual know your address or details about your family or personal life. In the office, keep photographs of your family out of sight; remove plaques or mementos that give personal information.

Major Depression

A major depression is a sustained period (at least two weeks) during which an individual experiences a depressed mood or a loss of interest or pleasure in most or all activities. During this period, the individual may also exhibit other symptoms of depression. Twice as many women as men suffer from major depression.

DSM-IV Diagnostic Criteria for a Major Depressive Episode

For a diagnosis of major depression, at least five of the following symptoms must have been present every day, or almost all day, over a two-week period. These symptoms will represent a change from previous functioning. A depressed mood, loss of interest or pleasure, or both will be among the symptoms.

- Depressed mood
- Disinterest or lack of enjoyment in usual activities
- Significant weight loss or weight gain when not dieting
- Insomnia or increased need for sleep (hypersomnia)
- Psychomotor agitation or psychomotor retardation
- Fatigue or loss of energy
- Feelings of worthlessness or excessive or inappropriate guilt
- Diminished concentration or ability to think clearly
- Recurrent thoughts of death, or suicidal thoughts, attempts, or plans

Associated Features of Major Depression

- Tearfulness
- Anxiety
- Irritability
- Brooding or obsessive rumination
- Excessive concern with physical health
- Phobia or panic attacks

Treatment Regime for Major Depression

The treatment regime for major depression includes the following:

- psychotherapy, often in conjunction with medication;
- antidepressant medications;
- antianxiety medications if the depression is accompanied by anxiety;

- antipsychotic medications for brief periods of time for severe depression with psychotic features, for example, depression accompanied by delusions and hallucinations; and
- hospitalization for severe cases.

Antidepressant medications do not take effect immediately and are generally prescribed for a period of six months or longer.

Supervision Issues for Major Depression

Some studies suggest that many depressed patients think about suicide and that as many as 10% to 15% successfully commit suicide. For example, suicide is a possibility with the white-collar individual who becomes severely depressed upon entering the criminal justice system for the first time and losing family, job, income, or friends because of the arrest or conviction.

The risk of suicide sometimes increases as the depressed person initially improves and regains the energy needed to plan and carry out the suicide. Monitor these cases for suicidal thoughts and gestures.

Individuals can take medication as long as six weeks before experiencing significant relief from depression symptoms. Sometimes those with major depression will not take their antidepressant medication because of its side effects (e.g., fatigue, dry mouth, constipation, blurred vision, muscle weakness, or lightheadedness) or because they feel better. Remind them that for antidepressant medications to be effective they must be taken every day, not only when the person feels depressed.

Major depression is a cyclic disorder consisting of periods of illness separated by periods of stable mental health. The psychiatrist or mental health treatment provider may recommend that the individual terminate treatment when the depressive episode ends. However, remain alert for renewed signs of depression. Encourage the individual to return to therapy for a progress check if mild depression returns, rather than wait until he or she is seriously depressed.

Bipolar Disorders (Manic and Manic-Depressive Illness)

Individuals with bipolar disorders suffer one or more manic episodes, usually accompanied by one or more major depressive episodes. With manic-depressive illness, mood swings are sometimes separated by periods of normal mood. Equally prevalent in men and women, bipolar disorder affects an estimated 0.4% to 1.2% of the adult population.

DSM-IV Diagnostic Criteria and Associated Features for a Depressive Episode

Refer to the diagnostic criteria and associated features for major depression.

DSM-IV Diagnostic Criteria for a Manic Episode

- A distinct period of abnormally and persistently elevated, expansive, or irritable mood lasting for at least one week has occurred.
- During a period of mood disturbance, at least three of the following symptoms have persisted and have been present to a significant degree:
  - — grandiosity, inflated self-esteem;
  - — decreased need for sleep;
  - — increased talkativeness;
  - — flight of ideas or racing thoughts;
  - — distractibility, i.e., attention is too easily drawn to unimportant or irrelevant external stimuli;
  - — increase in goal-oriented activity (either socially, at work, at school, or sexually), or psychomotor agitation; or
  - — excessive involvement in pleasurable activities, with a lack of concern for the high potential for painful consequences, such as buying sprees, foolish business ventures, reckless driving, or casual sex.
- Mood disturbance is severe enough to cause marked impairment in occupational or social functioning or to necessitate hospitalization to prevent harm to others.

Associated Features of a Manic Episode

- Inability to recognize presence of an illness; resistance to treatment
- Rapid shift to depression or anger
- Hallucinations or delusions
- Euphoric, elevated, expansive, or irritable mood

Treatment Regime for Bipolar Disorders

The treatment regime for bipolar disorders includes the following:

- Psychotherapy is often used in conjunction with medication.
- Lithium is the standard drug treatment for acute manic episodes. Depakote (valproic acid) is also frequently used.
- Antidepressant medications are sometimes prescribed for bipolar disorders, but the patient must be carefully observed for the emergence of manic symptoms.
- Antipsychotic, and sometimes antianxiety, medications are occasionally used at the initiation of treatment to control agitation.
- Hospitalization may be necessary during acute phases of the illness.

Lithium can be toxic. When a patient first starts taking lithium, doctors will take blood samples frequently until they know that the proper dosage is established in the patient's bloodstream. To ensure compliance with treatment, and the efficacy and safety of the drug, blood samples may be taken every three months to measure the level of the lithium in the bloodstream.

Supervision Issues for Bipolar Disorders

During a manic episode, poor judgment, hyperactivity, and other symptoms of the disorder may lead an individual into activities such as reckless driving, foolish business ventures, spending sprees, or involvement in crime.

When an individual is experiencing a major depressed state, monitor him or her for suicidal thoughts or gestures. Sometimes involuntary hospitalization is required to prevent harm to the self or others.

Although elevated mood is the primary symptom of a manic episode, in instances where the individual is hindered or frustrated in some manner, the mood disturbance

may be characterized by complaints, irritability, hostile comments, or angry tirades. The individual may become threatening or violent.

Noncompliance with the medication regime is a common supervision problem because of the side effects of antimanic and antidepressant medications and because many individuals like the euphoric feelings associated with manic episodes. Remind them that antimanic and antidepressant medications must be taken over a period of several weeks to be effective and that the medications must be taken every day.

Many individuals with bipolar disorder will need to take medication and participate in treatment during the entire supervision period.

Schizophrenia

Schizophrenia is a group of disorders manifested by disturbances in communication, language, thought, perception, affect, and behavior that last longer than six months.

DSM-IV Diagnostic Criteria for Schizophrenia

- Characteristic psychotic symptoms (1, 2, or 3, below) are present in the active phase for at least one week (unless the symptoms are successfully treated).
  - — 1. Two of the following:
    - (a) delusions
    - (b) hallucinations
    - (c) incoherent or disorganized speech
    - (d) catatonic behavior
    - (e) flatly or grossly inappropriate affect
    - (f) disorganized speech
  - — 2. Bizarre delusions
  - — 3. Prominent hallucinations of a voice or voices
- During the course of the disturbance, the person's ability to work, interact with others, and take care of himself or herself is markedly below the highest level achieved before onset of the disturbance.
- Schizoaffective disorder and mood disorder with psychotic features have been ruled out.

- Signs of disturbance persist for at least six months. The six-month period must include an active phase (of at least one week—less if symptoms have been successfully treated) during which there were psychotic symptoms, with or without a prodromal or residual phase, as defined below.

  Prodromal phase: a clear deterioration in functioning before the active phase of the disturbance that is not due to a mood disorder or to a psychoactive substance abuse disorder, and that involves at least two of the symptoms listed below.

  Residual phase: following the active phase of the disturbance, persistence of at least two of the symptoms listed below; symptoms are not due to a mood disorder or to a psychoactive substance abuse disorder.

  Prodromal or residual symptoms:

  — marked social isolation or withdrawal;

  — marked impairment in role functioning as wage earner, student, or homemaker;

  — peculiar behavior, such as collecting garbage or hoarding food;

  — marked impairment in personal hygiene and grooming;

  — blunted or inappropriate affect;

  — digressive, vague, over elaborate, or circumstantial speech; poverty of speech; or poverty of content of speech;

  — odd beliefs or magical thinking that influences behavior and is inconsistent with cultural norms, such as a belief in clairvoyance or telepathy;

  — unusual perceptual experiences, such as recurrent illusions; or

  — marked lack of initiative, interests, or energy.

Associated Features of Schizophrenia

- Perplexed or disheveled appearance
- Abnormal psychomotor activity, such as rocking or pacing
- Poverty of speech: brief and unelaborated responses to inquiries
- Depression, anger, or anxiety
- Depersonalization and derealization
- Ritualistic or stereotypical behavior
- Bizarre concerns with physical health (e.g., a conviction that limbs are artificial or that saliva is poisoned with no evidence that this is true)
- Excessive concern with physical health

Types of Schizophrenia

The diagnosis of a particular type should be based on the predominant clinical picture that occasioned the most recent evaluation or admission to clinical care.

- Catatonic type, in which the clinical picture is dominated by at least two of the following:
  - — catatonic stupor (marked decrease in ability to react to the environment);
  - — catatonic negativism (motiveless resistance to all instructions or attempts to be moved);
  - — catatonic rigidity (maintenance of a rigid posture);
  - — catatonic excitement (purposeless excited motor activity); and
  - — catatonic posturing (voluntary assumption of inappropriate or bizarre posture).
- Disorganized type, in which the following criteria are met:
  - — incoherence, marked loosening of associations, or grossly disorganized behavior;
  - — flat or grossly inappropriate affect; and
  - — criteria for catatonic type unmet.
- Paranoid type, in which there are:
  - — preoccupation with one or more systematized delusions or with frequent auditory hallucinations related to a single theme; and
  - — none of the following: incoherence, marked loosening of associations, flat or grossly inappropriate affect, catatonic behavior, or grossly disorganized behavior.
- Undifferentiated type, in which there are
  - — prominent delusions, hallucinations, incoherence, or grossly disorganized behavior; and
  - — the criteria for paranoid, catatonic or disorganized type are unmet.
- Residual type in which there is
  - — absence of delusions, hallucinations, incoherence, or grossly disorganized behavior;
  - — continuing evidence of illness or disturbance, as indicated by two or more of the residual symptoms of schizophrenia (e.g., flattened affect and poverty of speech).

Treatment Regime for Schizophrenia

The treatment regime for schizophrenia includes the following:

- antipsychotic medications;
- supportive therapy;
- hospitalization during acute periods of illness;
- outpatient follow-up to administer and monitor medication;
- day treatment or group home programs; and
- recreational, group, or vocational support therapy (potentially necessary to help the individual function).

Many persons with schizophrenia can only maintain emotional and mental stability by taking medication. Although any medical physician can prescribe anti-psychotic medication, a psychiatrist should be the primary treatment provider because medication is such an important part of the treatment regime.

Antipsychotic medications treat the symptoms of the illness; medications are not a cure for schizophrenia. See Appendix C for more information on antipsychotic medications. Long-term use of some antipsychotic medications may result in serious side effects including Parkinsonian effects (rigidity, shuffling gait, stooped posture, and drooling) or tardive dyskinesia (abnormal, involuntary, irregular movements of the muscles in the head and body, including darting, twisting, and protruding movements of the tongue; chewing and lateral jaw movement; and grimacing around the eyes and mouth).

Supervision Issues for Schizophrenia

People with schizophrenia are often impaired in several areas of routine daily functioning, such as work, social relations, and ability to care for self. Placement in a group house or structured day treatment program may be necessary to ensure that the person is properly fed and clothed and to protect the individual from the consequences of poor judgment, impaired thinking, or actions based on hallucinations or delusions. Some individuals require these support services for the duration of the supervision period.

DSM-IV indicates that patients with schizophrenia have a higher rate of suicide than the general population. Studies indicate that nearly half of all patients with

schizophrenia attempt suicide and that approximately 10% succeed. Monitor cases with schizophrenia for suicidal thoughts or gestures.

Noncompliance with the medication regime as a result of the medication's side effects is a common supervision problem. Those with schizophrenia may become noncompliant with other conditions of supervision or dangerous to themselves or others when they stop taking their medication. Monitor their behavior for indications of not following the prescribed medication regime.

Many cases with schizophrenia require mental treatment throughout supervision. With continual antipsychotic medication and treatment, individuals with schizophrenia can live relatively normal lives.

Research indicates that violence is no more common in patients with schizophrenia than in the general population. However, be alert to the potential for violent behavior when the individual has a history of aggression or assault, fails to comply with the medication regime, or experiences a psychotic episode.

Paranoid schizophrenia

DSM-IV lists violence as an associated feature of paranoid schizophrenia, presenting a possible third-party or officer safety risk, particularly if an individual forms persecutory delusions concerning the officer. Only office contacts should be scheduled with those who exhibit paranoid symptoms and who do not take their medication regularly. Alert the receptionist and building security that the individual will be reporting to the office.

Panic Disorder

Panic disorder is characterized by recurrent panic attacks, that is, discrete periods of fear or discomfort, often accompanied by a sense of impending doom.

DSM-IV Diagnostic Criteria for Panic Disorder

- At some time during the disturbance, one or more panic attacks have occurred that were unexpected and were not triggered by situations in which the person was the focus of others' attention.

- Either four attacks occurred within a four-week period, or one or more attacks were followed by at least a month of persistent fear of having another attack.
- At least four of the following symptoms developed during at least one of the attacks:
  - shortness of breath or smothering sensations
  - dizziness, unsteady feelings, or faintness
  - palpitations or accelerated heart rate
  - trembling or shaking
  - sweating
  - feeling of choking
  - nausea or abdominal distress
  - depersonalization or derealization
  - numbness or tingling sensations
  - hot flashes or chills
  - chest pain or discomfort
  - fear of dying
  - fear of going crazy or doing something uncontrolled.
- During at least some of the attacks, at least four of the above symptoms developed suddenly and increased in intensity within ten minutes of the beginning of the first symptom.

Associated Features of Panic Disorder

- Nervousness or apprehension between attacks
- Coexisting depressive disorder
- Alcohol abuse or antianxiety medication abuse

Treatment Regime for Panic Disorder

The treatment regime for panic disorder includes the following:

- behavior therapy
- insight-oriented psychotherapy
- antianxiety medications.

Supervision Issues for Panic Disorder

A panic attack generally begins with a ten-minute period of rapidly increasing symptoms and lasts twenty to thirty minutes. During an attack, the individual may appear confused, have trouble concentrating, experience physical symptoms, such as sweating or shaking, and not be able to name the source of the fear. If you observe an individual having a panic attack, quietly and calmly reassure him or her that the attack will pass, that he or she will be fine, and that you will not leave. After the attack, encourage the person to contact his or her treatment provider.

Phobias

A phobia is a persistent or irrational fear of, and a powerful desire to avoid, an object, situation, or place.

DSM-IV Diagnostic Criteria for Specific Phobia

- Persistent fear of an object or situation, other than fear of having a panic attack (as in panic disorder) or of humiliation or embarrassment in certain social situations (as in social phobia).
- Exposure to the specific phobic stimulus (or stimuli) almost invariably provokes an immediate anxiety response that may take the form of a panic attack.
- The object, situation, or place is avoided, or endured with intense anxiety.
- Fear or the avoidance behavior interferes with the individual's normal routine or with social activities or relationships with others, or there is marked distress about having the fear.
- Realization that the fear is unreasonable or excessive.
- The phobic stimulus is unrelated to the content of the obsessions of obsessive-compulsive disorder or the trauma of post-traumatic stress disorder.

Associated Features of Phobias

- Lifestyle or occupational restrictions
- Panic disorder or other phobia
- Depression

Subtypes of Phobias

- Social phobia is characterized by the following:
  - — persistent fear of one or more situations in which the person is exposed to possible scrutiny by others and fears that he or she may do something or act in a way that will be humiliating or embarrassing;
  - — phobic situation is avoided, or is endured with intense anxiety;
  - — avoidance behavior interferes with occupational functioning or with usual social activities or relationships with others, or there is marked distress about having the fear; and
  - — person recognizes that his or her fear is excessive or unreasonable.
- Panic disorder with agoraphobia is characterized by the following:
  - — meets the criteria for panic disorder; and
  - — fear of places or situations from which escape might be difficult (or embarrassing) or in which help might not be available in the event of a panic attack. As a result of this fear, the person either restricts travel or needs a companion when away from home, or else endures agoraphobic situations despite intense anxiety. Common agoraphobic situations include being outside the home alone, being in a crowd or standing in a line, being on a bridge, and traveling in a bus, train, or car.
- Agoraphobia without history of panic disorder is characterized by the following:
  - — fear of being in places or situations from which escape might be difficult (or embarrassing) or in which help might not be available in the event of suddenly developing a symptom that could be incapacitating or extremely embarrassing; and
  - — has never met the criteria for panic disorder.
- Simple phobias, such as
  - — acrophobia (fear of heights)
  - — claustrophobia (fear of closed spaces)
  - — blood-injury phobia (fear of witnessing blood or tissue injury)
  - — fear of animals
  - — fear of air travel.

Treatment Regime for Phobias

The treatment regime for phobias includes the following:

- behavior therapy
- insight-oriented psychotherapy
- antianxiety or antidepressant medications during acute phases of illness.

Supervision Issues for Phobias

Most persons with phobias live relatively normal lives because they simply avoid the phobic object or situation. However, some phobias may require special accommodations. For example, an individual with a phobia involving elevators or heights may not be able to report to the probation office if it is in a high-rise building. The contact could be scheduled in the building lobby or the individual's home. Do not allow an individual's phobia, susceptibility to panic attacks, or other anxieties to keep the individual from complying with the conditions of supervision.

Post-Traumatic Stress Disorder

Individuals develop post-traumatic stress disorder following exposure to extreme traumatic stressors—by directly experiencing an event that involves actual or threatened death or serious injury or some other threat to one's physical integrity; by witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or by earning about an unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate (e.g., military combat, rape, assault, or natural disaster).

DSM-IV Diagnostic Criteria for Post-Traumatic Stress Disorder

- The person has been exposed to a traumatic event in which he or she
  - — experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury or a threat to the physical integrity of self or others and
  - — responded with intense fear, helplessness, or horror.

- The traumatic event is persistently re-experienced in one (or more) of the following ways:
  - — recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions;
  - — recurrent distressing dreams of the event;
  - — acting or feeling as if the traumatic event were recurring (including a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated);
  - — intense psychological distress when exposed to internal or external cues that symbolize or resemble an aspect of the traumatic event;
  - — physiological reactions on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
- Persistent avoidance of stimuli associated with the traumatic event and numbing of general responsiveness (not present before the trauma), as indicated by three or more of the following:
  - — efforts to avoid thoughts, feelings, or conversations associated with the trauma;
  - — efforts to avoid activities, places, or people that arouse recollections of the trauma;
  - — inability to recall an important aspect of the trauma;
  - — markedly diminished interest or participation in significant activities;
  - — feelings of detachment or estrangement from others;
  - — restricted range of affect (e.g., inability to have loving feelings);
  - — sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span).
- Persistent symptoms of increased arousal (not present before the trauma), as indicated by two or more of the following:
  - — difficulty falling asleep or staying asleep;
  - — irritability or outbursts of anger;
  - — difficulty concentrating;
  - — hypervigilance;
  - — exaggerated startle response.

- Duration of the disturbance (symptoms above) is more than one month.
- The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Associated Features of Post-Traumatic Stress Disorder

- Guilt feelings about surviving trauma or being a "participant" in past childhood physical or sexual abuse.
- Phobic avoidance of situations or activities that resemble or symbolize the original trauma which may lead to interpersonal, marital, or job problems.
- Impaired ability to modulate moods or anxiety.
- Flashbacks
- Lapses of memory
- Panic attacks
- Self-destructive, self-mutilating, or impulsive behavior
- Feelings of ineffectiveness, shame, despair, hopelessness, damage, or social withdrawal
- Increased possible concurrence of panic disorder, other anxiety disorders, obsessive-compulsive disorder, depression, somatization, and substance abuse related disorders.

Treatment Regime for Post-Traumatic Stress Disorder

The treatment regime for post-traumatic stress disorder includes the following:

- psychotherapy
- group therapy for specific trauma (e.g., incest, child abuse, accident, combat, rape)
- psychotropic drugs for controlling associated panic attacks, anxiety, depression, and, in severe cases, delusional thoughts.

Supervision Issues for Post-Traumatic Stress Disorder

Beware of emotional instability or mood swings. Guilt, depression, and reenactment of trauma may result in self-destructive and self-mutilating behavior, including suicidal gestures.

Cases with Post-Traumatic Stress Disorder may attempt to "self-medicate" with alcohol and drugs. Monitor such abuse.

Cases with Post-Traumatic Stress Disorder may suffer from panic attacks, flashbacks, and agoraphobia and therefore may not be malingering in expressing difficulty dealing with reasonable supervision requirements. Work with a mental health professional to establish reasonable limits and demands.

Obsessive-Compulsive Disorder

Obsessive-compulsive disorder is characterized by recurrent obsessions or compulsions that are distressful, time-consuming, and interfere significantly with the individual's occupational and social functioning.

DSM-IV Diagnostic Criteria for Obsessive-Compulsive Disorder

- Either obsessions or compulsions:

  Obsessions

  — recurrent and persistent ideas, thoughts, impulses, or images causing marked anxiety or distress that are experienced, at least initially, as intrusive and "senseless" (e.g., a parent's having repeated impulses to kill a loved child, or a religious person's having recurrent blasphemous thoughts);

  — the person attempts to ignore or suppress such thoughts or impulses or to neutralize them with some other thought or action;

  — the person recognizes that the obsessions are created within his or her own mind and are not imposed from without

  — if another Axis I disorder is present, the content of the obsession is unrelated to it (e.g., the ideas, thoughts, impulses, or images are not about food in the presence of an eating disorder, about drugs in the presence of a psychoactive substance abuse disorder, or guilty in the presence of a major depression); and

  — the thoughts, images, or impulses are not simply excessive worries about real-life problems.

  Compulsions

  — repetitive behaviors (hand washing, checking) or mental acts (repeating words silently, counting) that are performed in response to an obsession, according to certain rules, or in a stereotyped fashion;

— the behavior or mental act is designed to neutralize or prevent discomfort or some dreaded event or situation; however, either the activity is not connected in a realistic way with what it is designed to neutralize or prevent, or it is clearly excessive; and

— the person realizes that the compulsions are excessive and unreasonable.

Associated Features of Obsessive-Compulsive Disorder

- Hypochondria
- Tension if the compulsive activity is not performed
- Avoidance of situations that involve the content of the obsession

Treatment Regime for Obsessive-Compulsive Disorder

The treatment regime for obsessive-compulsive disorder includes the following:

- behavior therapy
- psychotherapy
- antianxiety or antidepressant medications during acute phases of illness. (Note: The mechanisms of certain antidepressant medications are sometimes effective for obsessive-compulsive disorder.)

Supervision Issues for Obsessive-Compulsive Disorder

DSM-IV indicates that excessive alcohol or sedative drug use may be a complication of this disorder. Monitor the individual's alcohol and drug use.

Other Disorders of Impulse Control

Many mental and personality disorders can or do involve problems with or loss of impulse control. For example, substance abuse disorders, eating disorders, obsessive-compulsive disorders, paraphilias, and some symptoms of mood, personality, and schizophrenic disorders may involve difficulty controlling impulses. The essential feature of an impulse-control disorder is the failure to resist an impulse, drive, or temptation to perform an act that is harmful to the person or to other persons. For most of the disorders in this category, the individual feels an increasing sense of tension or arousal before the act and pleasure, gratification, or relief while committing

it. The act may or may not be followed by regret, self-reproach, or guilt. The following disorders are included:

- intermittent explosive disorder
- kleptomania
- pyromania
- pathological gambling

DSM-IV criteria for intermittent explosive disorder, kleptomania, pyromania, and pathological gambling are listed below to familiarize officers with the pathological basis of such behavior.

DSM-IV Diagnostic Criteria for Intermittent Explosive Disorder

- Several discrete episodes of failure to resist aggressive impulses that result in serious assault or destruction of property.
- The degree of aggressiveness expressed during the episodes is grossly out of proportion to any precipitating psychosocial stressors.
- The aggressive episodes are not better accounted for by another mental disorder (e.g., antisocial personality disorder, borderline personality disorder, a psychotic disorder, a manic episode, conduct disorder, or attention-deficit hyperactivity disorder) and are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., head trauma, Alzheimer's disease).

DSM-IV Diagnostic Criteria for Kleptomania

- Recurrent failure to resist impulses to steal objects that are not needed for personal use or for their monetary value.
- Increasing sense of tension immediately before the theft.
- Pleasure, gratification, or relief at the time of the theft.
- The stealing is not committed to express anger or vengeance and is not in response to a delusion or a hallucination.
- The stealing is not better accounted for by conduct disorder, a manic episode, or antisocial personality disorder.

DSM-IV Diagnostic Criteria for Pyromania

- Deliberate and purposeful fire setting of fires more than once.
- Tension or excitement before the act.
- Fascination with, interest in, curiosity about, or attraction to fire, its paraphernalia, uses, and consequences, etc.
- Pleasure, gratification, or relief when setting fires, or when witnessing or participating in their aftermath.
- The fires are set not for monetary gain, to express sociopolitical ideology, to conceal criminal activity, to express anger or vengeance, to improve the person's living circumstances, in response to a delusion or hallucination, or as a result of impaired judgment (e.g., in dementia, mental retardation, substance intoxication).
- The behavior is not better accounted for by conduct disorder, a manic episode, or antisocial personality disorder.

DSM-IV Diagnostic Criteria for Pathological Gambling

- Persistent and recurrent maladaptive gambling behavior as indicated by five (or more) of the following:
  - — is preoccupied with gambling (e.g., reliving past gambling experiences, handicapping or planning the next venture, or thinking of ways to get money with which to gamble);
  - — needs to gamble with increasing amounts of money in order to achieve the desired excitement;
  - — has repeated unsuccessful efforts to control, cut back, or stop gambling;
  - — is restless or irritable when attempting to cut down or stop gambling;
  - — gambles as a way of escaping from problems or of relieving a dysphoric mood (e.g., feelings of helplessness, guilt, anxiety, depression)
  - — after losing money gambling, often returns another day to get even ("chasing" one's losses);
  - — lies to family members, therapist, or others to conceal the extent of gambling;
  - — has committed illegal acts such as forgery, fraud, theft, or embezzlement to finance gambling;

- — has jeopardized or lost a significant relationship, job, or educational or career opportunity because of gambling;
- — relies on others to provide money to relieve a desperate financial situation caused by gambling.

- The gambling behavior is not better accounted for by a manic episode.

Paraphilias

The essential feature of disorders in this subclass is sexual arousal in response to objects or situations that are not part of normal sexual arousal activities. It may interfere with the individual's capacity for normal, reciprocal, affectionate sexual activity. An individual may suffer from several types of paraphilia.

DSM-IV Diagnostic Criteria for Paraphilias

- Recurrent, intense sexual urges and sexually arousing fantasies involving:
  - — nonhuman objects;
  - — children or non-consenting adults; or
  - — the suffering or humiliation of oneself or one's partner.
- The person has acted on these urges, or is markedly distressed by them.

Associated Features for Paraphilias

- Use of specific stimuli or imagery in sexual fantasies
- Personality disturbances that may be severe enough to warrant an Axis II diagnosis
- Decreased ability or inability to participate in normal, affectionate sexual relationships
- Denial that the paraphilic behavior is a source of stress for the individual, and the assertion that problems emerge from society's reaction to the behavior

Types of Paraphilias

- Exhibitionism: intense sexual urges and sexual fantasies associated with exposing one's genitals to a stranger; without further sexual activity with the stranger.
- Fetishism: intense sexual urges and sexual fantasies involving the use of nonliving objects.

- Frotteurism: intense sexual urges and sexual fantasies involving touching or rubbing against a non-consenting person.
- Pedophilia: intense sexual urges and sexual fantasies involving sexual activity with a child.
- Sexual masochism: intense sexual urges and sexual fantasies involving the act of being humiliated, bound, beaten, or otherwise made to suffer.
- Sexual sadism: intense sexual urges and sexual fantasies involving acts in which the individual causes psychological or physical suffering, humiliation, or harm to another person.
- Transvestic fetishism: intense sexual urges and sexual fantasies involving cross-dressing.
- Voyeurism: intense sexual urges and sexual fantasies involving observing unsuspecting people (usually strangers) who are naked, disrobing, or engaging in sexual activity.
- Paraphilia not otherwise specified: paraphilias that do not meet the criteria for any of the other types of paraphilia. Examples include (erotic stimulus in parenthesis):
  - telephone scatologia (lewdness);
  - necrophilia (corpses);
  - partialism (particular part of the body);
  - zoophilia (animals);
  - coprophilia (feces);
  - klismaphilia (enemas); and
  - urophilia (urine).

Treatment Issues for Paraphilias

The treatment regime for paraphilias includes the following:

- specialized psychotherapy;
- sex hormone treatment in extreme cases; and
- antidepressant medications to treat compulsive sexual behaviors.

Depo-provera, a hormone that decreases sexual drive, as well as the severity and frequency of aberrant sexual fantasies, is sometimes used to treat paraphiliacs. The medication is administered by injection on a weekly basis. Its use is highly

controversial and has been the subject of a great deal of litigation. It may be administered only if the individual has consented to its use.

Supervision Issues for Paraphilias

Many individuals with paraphilias do not respond well to traditional psychotherapy. Whenever possible, refer the individual to a therapist or clinic specializing in the treatment of paraphilia.

Sex offender treatment teaches coping skills to help the individual resist acting on his or her abnormal sexual interests; it does not cure the paraphilia. Relapse prevention is a critical part of the treatment regime and generally consists of requiring the individual to attend aftercare groups and focusing therapy on one's sexually abusive and deviant behavior.

The clinical polygraph has been used in recent years to identify individuals involved in past and current sexual offenses and has become an integral part of many sex offender treatment programs. The clinical polygraph is merely a diagnostic tool to elicit admissions from, and to detect deception by, the sex offender to aid supervision and treatment. It is not admissible in court and should not be used in a court proceeding.

Individuals should be in treatment throughout the supervision period. If the treatment provider and the officer jointly determine that treatment may be terminated, the sex offender should be closely monitored for the remainder of the supervision period.

Managing risk is the primary focus of supervision and necessitates an extraordinary amount of contact with both the offender and the treatment provider. Consider the following supervision strategies:

- Restrict the offender's employment and recreational activities. Offenders with paraphilia should not be able to come in contact with potential victims. For example, pedophiles and child molesters should not be allowed to work in a day-care centers, drive school buses, or frequent public swimming pools, school playgrounds, or video arcades. In general, no arrested or convicted sex offender should be allowed to work in an adult bookstore.
- Restrict the offender's travel. Offenders with paraphilias often travel to find new victims.

- Monitor the offender's contact with victims. Victims should be told that any contact with the offender should be brought to the immediate attention of the officer.
- Work with local law enforcement and with law enforcement agencies that investigate sex offense-related crimes, including U.S. Customs, U.S. Postal Inspectors, and the FBI. Most metropolitan police departments have units that specialize in the investigation of sex offenders.
- Verify compliance with local and state sex offender registration laws, when applicable. Failure to register as required may constitute a violation of state law, which in turn constitutes a violation of the conditions of release.
- Whenever possible, refer the sex offender to a therapist or clinic specializing in the treatment of paraphilias.

Suicide is a possibility for some sex offenders who experience severe depression upon entering the criminal justice system. For example, a middle-class offender who loses family, friends, job, and personal reputation because of an arrest or conviction for child molestation may become suicidal.

Paranoid Personality Disorder

Paranoid personality disorder involves a pervasive and unwarranted tendency, beginning by early adulthood, to interpret the actions of others as deliberately threatening and demeaning. This disorder is more commonly diagnosed in men than in women.

DSM-IV Diagnostic Criteria for Paranoid Personality Disorder

To be diagnosed as having paranoid personality disorder, an individual must exhibit at least four of the following:

- expects, without sufficient basis, to be exploited, deceived, or harmed by others;
- questions, without justification, the loyalty or trustworthiness of friends or associates;
- reads hidden demeaning or threatening meanings into benign remarks or events (e.g., suspects that a neighbor put out trash early to annoy him or her);
- bears grudges or is unforgiving of insults or slights;

- is reluctant to confide in others because of the unwarranted fear that the information will be used against him or her;
- is easily slighted and quick to react with anger or to counterattack; or
- questions, without justification, fidelity of a spouse or sexual partner.

Associated Features of Paranoid Personality Disorder

- Hostility, defensiveness, or stubbornness
- Argumentativeness, recurrent complaining, hostile aloofness
- Inflexibility, criticalness of others, inability to collaborate
- Avoidance of intimacy or group activities
- Excessive need for self-sufficiency
- Restricted affect that prevents individual from being warm, affectionate, or emotional
- Attraction to simplistic formulations of the world; tendency to develop negative stereotypes of cultural groups distinct from his or her own
- During periods of extreme stress, transient psychotic symptoms, but usually of insufficient duration to warrant an additional diagnosis

Treatment Regime for Paranoid Personality Disorder

The treatment regime for paranoid personality disorder is psychotherapy, preferably individual therapy.

Supervision Issues for Paranoid Personality Disorder

Cases with paranoid personality disorder are sometimes argumentative, hostile, irritable, or angry. Often, they experience lifelong problems with working and living with others. They may need help framing their perceptions more realistically and projecting their own hostile or unacceptable feelings onto others.

Schizoid Personality Disorder

A lifelong pattern of social withdrawal and a restricted range of emotional experience and expression characterize schizoid personality disorder.

DSM-IV Diagnostic Criteria for Schizoid Personality Disorder

To be diagnosed as having schizoid personality disorder, an individual must exhibit at least four of the following:

- neither desires nor enjoys close relationships, including being part of a family;
- almost always chooses solitary activities;
- takes pleasure in few, if any activities;
- indicates little, if any, desire to have sexual experiences with another person;
- is indifferent to praise or criticism;
- has no close friends or confidants outside immediate family; or
- displays constricted affect; is aloof and cold and rarely reciprocates gestures or facial expressions, such as smiles or nods.

Associated Features of Schizoid Personality Disorder

- Inability to express aggressiveness or hostility
- Inability to define goals; indecisiveness, self-absorption, and absent-mindedness

Treatment Regime for Schizoid Personality Disorder

The treatment regime for schizoid personality disorder is psychotherapy, and sometimes medication is used as well.

Supervision Issues

The individual's withdrawing style should be countered by enhancing personal, social, and professional spheres.

Schizotypal Personality Disorder

Schizotypal personality disorder involves a pervasive pattern of acute discomfort with and reduced capacity for interpersonal relationships, as well as peculiarities of ideation, appearance, and behavior.

DSM-IV Diagnostic Criteria for Schizotypal Personality Disorder

To be diagnosed as having schizotypal personality disorder, an individual must exhibit at least five of the following:

- ideas of reference (excluding delusions of reference);
- excessive social anxiety (e.g., extreme discomfort in social situations involving unfamiliar people);
- odd beliefs or magical thinking which influences behavior and is inconsistent with cultural norms (e.g., clairvoyance, telepathy);
- unusual perceptual experiences, such as illusions or sensing the presence of a force or person not actually present;
- odd or eccentric appearance or behaviors, such as talking to himself or herself;
- lack of close friends or confidants outside immediate family;
- odd speech, such as impoverished, vague, or digressive speech;
- silly, aloof, or inappropriate facial expressions or gestures; or
- suspiciousness or paranoid ideas.

Associated Features of Schizotypal Personality Disorder

- Anxiety or depression
- Eccentric convictions
- During periods of extreme stress, may experience transient psychotic symptoms, but these symptoms are usually of insufficient duration to warrant an additional diagnosis

Treatment Regime for Schizotypal Personality Disorder

The treatment regime for schizotypal personality disorder is psychotherapy, and sometimes medication is used as well.

Supervision Issues for Schizotypal Personality Disorder

Those with schizotypal personality disorder are likely to be involved in bizarre groups, cults, or strange religious practices. Their companions may be eccentric and unpredictable. As a precaution, the first contact with the individual should be in the office. To the extent possible, before making subsequent home contacts determine who is living in the home or who frequently visits the home.

Ten percent of all patients with schizotypal personality disorder commit suicide. Monitor cases with this disorder for signs of suicidal thoughts and gestures.

Antisocial Personality Disorder

Antisocial personality disorder is characterized by an inability to conform to social norms and a continuous display of irresponsible and antisocial behavior. A diagnosis of antisocial personality disorder can only be made after age 18 and must include evidence of antisocial conduct that began prior to age 15. This disorder is more common in men than in women. As much as 75% of the prisoner population may have antisocial personality disorder.

DSM-IV Diagnostic Criteria for Antisocial Personality Disorder

- Current age at least 18.
- Evidence of conduct disorder with onset before age 15, as indicated by a history of three or more of the following:
  - — often bullied, threatened, or intimidated others;
  - — was often truant;
  - — before age 13, stayed out all night despite parental restrictions;
  - — ran away from home overnight at least twice while living in parental or parental surrogate’s home;
  - — often initiated physical fights;
  - — used a weapon in more than one fight;
  - — forced someone into sexual activity with him or her;
  - — was physically cruel to animals;
  - — was physically cruel to other people;

- — deliberately destroyed others' property (other than by setting fires);
- — deliberately set a fire;
- — often lied (other than to avoid physical or sexual abuse);
- — has broken into another's house, building, or car;
- — has stolen without confronting the victim on more than one occasion; or
- — has stolen and confronted the victim (e.g., mugging or armed robbery).

- A pattern of irresponsible and antisocial behavior since age of 15, as indicated by at least four of the following:
  - — unable to sustain consistent work behavior, as indicated by any of the following:
    - significant unemployment for six months or more within five years when expected to work and work was available;
    - repeated absences from work unexplained by illness of self or family; or
    - abandonment of several jobs without realistic plans for others
  - — fails to conform to social norms with respect to lawful behavior, as indicated by repeatedly performing antisocial acts that are grounds for arrest;
  - — is irritable and aggressive, as indicated by physical fights or assaults;
  - — repeatedly fails to honor financial obligations, such as defaulting on debts;
  - — fails to plan ahead or is impulsive, as indicated by either a lack of a permanent address, traveling from place to place with no purpose in mind, or both;
  - — has no regard for truth, as indicated by repeatedly lying or using aliases;
  - — is reckless regarding his or her own or others' safety;
  - — lacks remorse.

Associated Features of Antisocial Personality Disorder

- Use of alcohol and drugs and engaging in casual sexual intercourse in early adolescence and adulthood
- Signs of personal distress, such as tension, depression, or boredom
- Inability to form or sustain healthy, loving relationships with family, friends, or sexual partners

Treatment Regime for Antisocial Personality Disorder

The treatment regime for antisocial personality disorder is psychotherapy.

Supervision Issues for Antisocial Personality Disorder

Some mental health providers find antisocial personality disorder difficult to treat and may refuse to take a referral. Prognosis for successful treatment is extremely poor.

Rely on supervision strategies more than treatment to manage risk. Some persons with this disorder are very charming and manipulative. Set, clarify, and enforce limits on behavior. Monitor these cases for drug and alcohol use and antisocial acts such as physical fights and assaults, association with criminals, reckless or drunk driving.

Antisocial personality disorder, in the presence of a history of aggressive behavior, increases the likelihood of continued aggressive behavior.

Borderline Personality Disorder

Borderline personality disorder is characterized by a pervasive pattern of unstable mood, self-image, and interpersonal relationships and marked impulsivity, beginning by early adulthood. This disorder is more prevalent in women than in men.

DSM-IV Diagnostic Criteria for Borderline Personality Disorder

To be diagnosed as having borderline personality disorder, an individual must exhibit at least five of the following:

- a pattern of unstable and intense interpersonal relationships characterized by alternation between extremes of idealization and devaluation;
- impulsiveness in at least two areas that are potentially self-damaging, such as excessive spending, casual sex, shoplifting, reckless driving, and binge eating;
- marked shifts in mood, leading to depression, anxiety, or irritability;
- inappropriate displays of intense anger or a lack of control concerning anger;
- recurrent suicidal threats, gestures, or behavior, or self-mutilating behavior;

- marked and persistent identity disturbance, as evidenced by at least two of the following: uncertainty about life issues, sexual orientation, life goals, career choices, choice of friends, and values;
- chronic feelings of boredom and emptiness;
- frantic efforts to avoid real or imagined abandonment;
- brief stress-related paranoid thinking or severe dissociative symptoms.

Associated Features of Borderline Personality Disorder

- Features of other personality disorders may be present and severe enough to warrant more than one diagnosis
- Pessimistic outlook and social contrariness
- Depression
- Alternation between self-assertion and dependency
- During periods of extreme stress, may experience transient psychotic symptoms, but they are usually of insufficient duration to warrant an additional diagnosis

Treatment Regime for Borderline Personality Disorder

The treatment regime for borderline personality disorder includes the following:

- psychotherapy;
- behavior therapy to help the individual control impulses and anger;
- insight oriented therapy;
- social skills training to help the individual improve interpersonal skills;
- antidepressant medications to treat depression and mood swings; and
- antipsychotic medication to control anger, hostility, and brief psychotic episodes.

Supervision Issues for Borderline Personality Disorder

Prognosis for treatment is extremely poor. These cases may play the treatment provider and the officer against each other. If possible, make referrals to a provider experienced in treating persons with borderline personality disorder. At the beginning

of treatment, schedule a meeting with all parties to discuss treatment goals. Remain vigilant for manipulative gestures throughout supervision.

Recurrent suicidal threats and behavior, or self-mutilation (e.g., slashing wrists or arms) are common in severe cases. Although the suicide or self-mutilating gestures may be manipulative, attention-seeking behaviors, treat these incidents as life threatening.

Hospitalization may be required when a person is excessively self-destructive or self-mutilating. Placement in a halfway house or group home may provide a helpful support system.

Because of their unpredictable and impulsive behavior, persons with borderline personality disorder are often in a state of extreme crisis involving problems with finances, health, relationships, or other areas of their lives. Focus supervision on defining acceptable and unacceptable behavior and parameters of compliance and providing structure that will enable the individual to comply.

Monitor drug or alcohol use.

These cases demonstrate poor judgment in relationships and frequently change partners. As a precaution, attempt to find out whom the individual is living with prior to making a home contact.

Females with borderline personality disorder are often seductive and may have trouble maintaining appropriate boundaries. Thus, it is often best to have another officer accompany you on home contacts.

A diagnosis of borderline personality disorder does not itself suggest violent, aggressive behavior toward others. It does suggest violent, destructive acts towards oneself and impulsiveness and anger that may at times result in violent acts toward others.

Histrionic Personality Disorder

Excessive emotionality and attention seeking characterize histrionic personality disorder. This disorder, which begins in early adulthood, is more commonly diagnosed in women than in men.

DSM-IV Diagnostic Criteria for Histrionic Personality Disorder

To be diagnosed as having histrionic personality disorder, an individual must exhibit at least four of the following:

- is often inappropriately sexually seductive in appearance or behavior;
- consistently uses physical appearance to draw attention to self;
- emotional expressions are inappropriately exaggerated, such as embracing casual acquaintances with excessive ardor or sobbing uncontrollably on minor sentimental occasions;
- is uncomfortable in situations in which he or she is not the center of attention;
- displays rapidly shifting and shallow expression of emotions;
- is easily influenced by other or circumstances;
- has a style of speech that is excessively impressionistic and lacking in detail (e.g., says "My vacation was fantastic!" without being able to provide details);
- considers relationships to be more intimate than they actually are.

Associated Features of Histrionic Personality Disorder

- Is lively and dramatic
- Craves novelty, stimulation, and excitement and is easily bored with routine
- Has superficial personal relationships
- Lacks interest in intellectual pursuits
- Is impressionable and easily influenced; is drawn to strong authority figures and thinks that they can provide a magical solution to his or her problems
- Frequently complains about poor health
- During periods of extreme stress, may experience transient psychotic symptoms, but they are usually of insufficient duration to warrant an additional diagnosis

Treatment Regime for Histrionic Personality Disorder

The treatment regime for histrionic personality disorder is psychotherapy.

Supervision Issues for Histrionic Personality Disorder

Cases with histrionic personality disorder have superficial relationships, although they have strong dependency needs. Seductive behavior is common in both male and females. Discourage it by defining the parameters of the officer-client relationship throughout the supervision period. To the extent possible, make home contacts in teams.

Persons with histrionic personality disorder sometimes appear to be in crisis because they are excessive in their expression of emotion. They are sensation seekers who may get into trouble with the law, abuse drugs, or act promiscuously.

Narcissistic Personality Disorder

Narcissistic personality disorder is characterized by a heightened sense of self-importance in fantasy or behavior, hypersensitivity to evaluation by others, and a lack of empathy.

DSM-IV Diagnostic Criteria for Narcissistic Personality Disorder

To be diagnosed as having narcissistic personality disorder, an individual must exhibit at least five of the following:

- shows arrogant, haughty behaviors or attitudes;
- takes advantages of others;
- has a grandiose sense of self-importance;
- believes that his or her problems are unique and can only be understood by other high-status, special people or institutions;
- is preoccupied with fantasies of unlimited success, power, brilliance, beauty, or ideal love;
- has an unreasonable expectation of favorable treatment;
- requires excessive admiration;
- lacks empathy;

- is preoccupied with feelings of envy.

Associated Features of Narcissistic Personality Disorder

- Features of other personality disorders may be present and severe enough to warrant more than one diagnosis
- Depression
- Preoccupation with grooming, personal health, and youth
- Rationalizing or lying about personal deficits
- Reacts to criticism with feelings of rage, shame, or humiliation.

Treatment Regime for Narcissistic Personality Disorder

The treatment regime for narcissistic personality disorder is psychotherapy.

Supervision Issues for Narcissistic Personality Disorder

The individual with narcissistic personality disorder is often arrogant, aloof, superior, and condescending. He or she is likely to play power games with the officer, and winning any of these games will only reinforce the narcissistic behavior. In addition, these cases have fragile self-esteem and are prone to suicide.

Individuals with narcissistic personality disorder respond negatively to aging and are susceptible to mid-life crises because they place excessive value on youth, beauty, and strength. Major depression can occur during this time.

Because these cases frequently experience interpersonal problems and exploit others to achieve their ends, rely on supervision strategies more than treatment to manage risk. Set, clarify, and enforce limits on behavior. Intensive supervision is recommended for the duration of supervision.

Avoidant Personality Disorder

Avoidant personality disorder is characterized by a pervasive pattern of social discomfort, hypersensitivity to negative evaluation, and feelings of inadequacy beginning by early adulthood.

DSM-IV Diagnostic Criteria for Avoidant Personality Disorder

To be diagnosed as having avoidant personality disorder, an individual must exhibit at least four of the following:

- is preoccupied with being criticized or rejected in social situations;
- shows restraint within intimate relationships because of the fear of being shamed or ridiculed;
- is unwilling to get involved with people unless certain of being liked;
- avoids social or occupational situations that involve significant interpersonal contact, because of fears of criticism, disapproval, or rejection;
- is inhibited in new social situations because of feelings of inadequacy;
- views self as socially inept, personally unappealing, or inferior;
- is unusually reluctant to take personal risks or to engage in any new activities because they may prove embarrassing.

Associated Features of Avoidant Personality Disorder

- Depression, anxiety, or anger at oneself for failing to develop social relationships
- Specific phobias, such as social phobia

Treatment Regime for Avoidant Personality Disorder

The treatment regime for avoidant personality disorder includes the following:

- psychotherapy
- assertiveness training—sometimes useful in building social and interpersonal skills and improving self-esteem.

Supervision Issues for Avoidant Personality Disorder

Whereas the person with schizoid personality disorder avoids social contact because he or she prefers to be alone, the person with avoidant personality disorder avoids social contact for fear of rejection. Many persons with avoidant personality disorder are able to function as long as they are in a safe, protected family environment. Should this support system fail, however, they may experience anger, depression, or anxiety.

Individuals with avoidant personality disorder generally respond poorly to the slightest perceived rejection or criticism and on rare occasions may avoid an officer because they are angry or hurt by something the officer said or did.

Dependent Personality Disorder

Dependent personality disorder is characterized by a pervasive and excessive need to be taken care of that leads to dependent and submissive behavior. This disorder, which begins by early adulthood, is more commonly diagnosed in women than in men.

DSM-IV Diagnostic Criteria for Dependent Personality Disorder

To be diagnosed as having dependent personality disorder, an individual must exhibit at least five of the following:

- is unable to make everyday decisions without an excessive amount of advice and reassurance from others;
- needs others to assume responsibility for most major areas of his or her life;
- agrees with people when he or she believes they are wrong because of a fear of being rejected;
- has difficulty initiating projects or doing things alone because of a lack of self-confidence in his or her own judgment or abilities rather than a lack of motivation;
- volunteers to do things that are unpleasant or demeaning in order to get others to like him or her;
- feels uncomfortable and helpless when alone, or goes to great lengths to avoid being alone;
- urgently seeks another relationship as a source of care and support when a close relationship ends;
- is frequently preoccupied with fears of being abandoned.

Associated Features of Dependent Personality Disorder

- Sometimes, features of other personality disorders severe enough to warrant more than one diagnosis

- Depression and anxiety
- Lack of self-confidence
- Easily hurt by criticism or disapproval.
- Belittling personal assets and abilities
- Seeking or encouraging relationships in which they are overprotected or dominated by others

Treatment Regime for Dependent Personality Disorder

The treatment regime for dependent personality disorder includes the following:

- psychotherapy, including behavior therapy, family therapy, and group therapy; and
- assertiveness training—sometimes useful for improving self-esteem.

Supervision Issues for Dependent Personality Disorder

Cases with this disorder will most likely have a long-standing relationship with one person upon whom they are grossly dependent. If anything should happen to that person or to the relationship, the individual might develop depression. Be aware of the status of this individual's relationship with his or her significant other and remain alert to the signs of possible depression or suicide when the relationship is unstable.

A person with dependent personality disorder may be involved in an abusive relationship. For example, he or she may have a physically abusive, unfaithful, or alcoholic spouse. The abuse may increase as the person becomes more self-sufficient through therapy and begins to display what the abusive partner perceives as independent or defiant behavior.

Obsessive-Compulsive Personality Disorder

Obsessive-compulsive personality disorder is characterized by a preoccupation with orderliness, perfectionism and mental and interpersonal control at the expense of flexibility, openness, and efficiency. It begins by early adulthood. *(Do not confuse this personality disorder with the Axis I obsessive-compulsive disorder.)* This disorder is more commonly diagnosed in men than in women.

DSM-IV Diagnostic Criteria for Obsessive-Compulsive Personality Disorder

To be diagnosed with obsessive-compulsive personality disorder, an individual must exhibit at least five of the following:

- perfectionism that interferes with task completion;
- preoccupation with details and organization, rules, order, or schedules to the extent that the major point of the activity is lost;
- unreasonable insistence that others submit to his or her ways of doing things, or unreasonable reluctance to allow others to do things because of the conviction that things will be done incorrectly;
- excessive devotion to work and productivity to the exclusion of leisure time and friendships;
- overly conscientious, inflexible, and scrupulous concerning matters of morality, ethics, or values (not accounted for by cultural or religious identifications);
- miserly spending style toward both self and others; money hoarded for future catastrophes;
- stinginess with time and material possessions when no personal gain is likely to result from sharing; or
- inability to discard worn-out or worthless objects.

Associated Features of Obsessive-Compulsive Personality Disorder

- Difficulty expressing warm and tender feelings or affection
- Indecisiveness that leads to personal distress
- Depression
- A need to control others or situations; individual ruminates or becomes angry if control cannot be attained
- Extreme sensitivity to social criticism

Treatment Regime for Obsessive-Compulsive Personality Disorder

The treatment regime for obsessive-compulsive personality disorder is psychotherapy.

Supervision Issues for Obsessive-Compulsive Personality Disorder

Anything that threatens to upset the individual's daily routine or rituals may cause him or her a great deal of anxiety. For example, unannounced home contacts are not recommended.

Chapter 2: Co-occurring Disorders

Recently, mental health professionals have been using the term *co-occurring disorders* to refer to both a substance abuse or dependence disorder and another Axis I disorder; and the term *dual diagnosis* to refer to both mental retardation and an Axis I disorder. Co-occurring disorders should not be confused with multiple diagnoses, which refers to more than one Axis I disorder or Axis II disorder or both an Axis I disorder and an Axis II disorder.

Mental health professionals estimate that as many as half the individuals with a mental disorder abuse alcohol or drugs. Co-occurring disorders have become the norm, rather than the exception, especially with individuals in the criminal justice system. Some common co-occurring disorders are major depression and alcohol abuse, and antisocial personality disorder and drug abuse.

Researchers and medical professionals debate whether mental disorders lead to substance abuse or vice versa. An individual with a mental disorder may self-medicate to ease symptoms of a mental disorder, thereby creating a substance abuse problem. Research indicates that excessive use of alcohol and drugs can result in mental disorders, such as anxiety and depression.

Individuals with co-occurring disorders may have a high rate of

- hospitalization;
- violent and criminal behavior;
- suicidal behavior;
- noncompliance with medication regimes; and
- housing instability and homelessness.

Treatment Issues

Many mental health and drug abuse therapists disagree on how to treat the individual with co-occurring disorders. For example, some mental health therapists believe that sobriety must be achieved before treatment for a psychological or psychiatric disorder

can begin. Conversely, some drug treatment providers will insist that the person be psychiatrically stabilized before being admitted to their programs. Some drug abuse facilities endorse a drug-free philosophy and refuse to treat individuals who are taking psychiatric medication. Many treatment programs are not designed to address the unique treatment needs of the individual with co-occurring disorders.

Direct the person with co-occurring disorders to a treatment facility that specializes in dual diagnosis in order to determine which condition occurred first. When this is not feasible, ensure that both mental health and substance abuse evaluators are aware of each other's involvement in the case so that between them they can determine which disorder occurred first and immediately start treatment for that disorder. Then locate a treatment provider for the disorder that occurred second. Coordinate the various treatment programs, making sure that all the problems are addressed. Ensure that medication information is shared with all the treatment providers involved in the case.

Generally, an individual with co-occurring disorders will require treatment throughout the supervision period.

Supervision Issues

Because individuals with co-occurring disorders suffer from two problems, they have a higher incidence of hospitalization, violent and criminal behavior, noncompliance with the medication regime, and housing instability and homelessness than other individuals with mental disorders. Depending on the mental disorder, some cases may be at increased risk for suicide. Monitor these cases for suicidal thoughts and gestures. Accidental death by overdose is a risk with this population.

For individuals with a history of co-occurring disorders, a very strict urine collection regimen should be maintained to determine if they are using drugs. These individuals should be educated regarding the hazards of mixing illicit drugs and prescribed medication. Alcohol or drug abusers should be required to attend some form of Alcoholics Anonymous or Narcotics Anonymous meetings regularly. Alcohol and drugs are both physically and psychologically addictive. You should expect relapses and possible lying about drug and alcohol use.

Whenever possible, do not schedule a home contact without first meeting the individual with co-occurring disorders in the office, treatment facility, or other safe location. Subsequent home contacts should be made with caution, preferably with another officer.

A history of violence, substance abuse, or psychotic episodes increases the potential for violence and third-party risk. For persons with co-occurring disorders, a recent psychiatric hospitalization significantly increases the risk of violence, especially within the first few months after discharge. Generally, the violence committed by individuals discharged from a hospital is very similar to violence committed by other people living in their communities in terms of type (i.e., hitting), target (i.e., family members), and location (i.e., at home).

Chapter 3: Child Molesters[6]

This chapter describes child molesters and provides information to help officers identify this type of offender and better manage the associated third-party risk.

Pedophile or Child Molester?

What is the difference between a child molester and a pedophile? For many, the terms have become interchangeable. There are, however, clear differences between the two types of individuals who sexually abuse children, and law enforcement officers handling such cases need to be aware of the distinctions.

A pedophile experiences recurrent, intense sexual urges and sexually arousing fantasies involving sexual activity with a child. Although a pedophile may have a sexual preference for children, if the pedophile does not act on this preference by actually molesting a child, that person is not a child molester. For example, some individuals engage in pedophilia by fantasizing and masturbating, or by simply watching or talking to children and later masturbating. Some have sex with dolls or mannequins that resemble children. Still others engage in sexual activities with adults who look like children (small stature, flat-cheated, no body hair) or dress or act like them. Others act out child fantasy games with adult prostitutes.

Conversely, not all child molesters are pedophiles. A person who prefers sexual relations with an adult may, for any number of reasons, have sex with a child. Such reasons might include availability, curiosity, stress, sexual experimentation, or a desire to hurt a loved one of the child. Since this individual's sexual preference is not for children, he or she is not a pedophile.

6. The material in this chapter is adapted from pages 5–9, 15–21, and 37–40 of *Child Molesters: A Behavioral Analysis* ©1992, authored by Kenneth V. Lanning in cooperation with the Federal Bureau of Investigation, U.S. Department of Justice, and published by the National Center for Missing and Exploited Children. It is reprinted with permission of the National Center for Missing and Exploited Children, Arlington, Virginia. All rights reserved.

Dr. Park Elliot Dietz divides child molesters into two broad categories: situational and preferential child molesters. Expanding on Dietz's ideas, Kenneth Lanning of the Behavioral Science Unit of the FBI developed a typology of child molesters for use by criminal justice professionals. Lanning avoids using diagnostic criteria in favor of descriptive terms. The purpose of this typology is not to gain insight into *why* child molesters have sex with children in order to help or treat them, but to recognize and evaluate *how* child molesters have sex with children in order to identify, arrest, and convict them. What evidence to look for, whether there are additional victims, how to interview a suspect, and so on, depend on the type of child molester involved.

Situational Child Molesters

The situational child molester does not have a true sexual preference for children, but engages in sex with children for a number of reasons. For such a child molester, sex with children may range from a once-in-a-lifetime act to a long-term pattern of abusive behavior. The more long-term the pattern of abuse, the harder it is to distinguish from preferential molesting. The situational child molester usually has fewer child victims. Other vulnerable individuals, such as the sick, elderly, or disabled, may also be at risk of sexual victimization by a situational child molester. Some law enforcement officials indicate that cases involving this type of child molester are increasing. Also, most of the profiles of sexually motivated child murderers developed by the FBI's Behavioral Science Unit involve situational child molesters. Members of lower socioeconomic groups tend to be over represented among situational child molesters.

There are four types of situational child molesters: regressed, morally indiscriminate, sexually indiscriminate, and inadequate.

Regressed Child Molester

The regressed child molester usually has low self-esteem and poor coping skills; the individual turns to the child as a sexual substitute for the preferred peer sexual partner. Precipitating stress may also play a role in the molester's behavior. The regressed child molester chooses victims based on availability, which is why many of these individuals molest their own children. The molester's method of operation is to coerce the child into having sex. This type of situational child molester may or may not collect child or adult pornography. If the molester does have child pornography, it will usually be the best kind from an investigative point of view: home videos or photographs of the offender's victims.

Morally Indiscriminate Child Molester

The morally indiscriminate child molester abuses everyone in his or her life—spouse, children, and co-workers. The molester is a user and abuser of people. The sexual abuse of children is simply part of the molester's general pattern of abusive behavior. This individual lies, steals, or cheats whenever possible and molests children for a simple reason—"why not?" The molester selects victims based on opportunity and vulnerability—if the molester has the urge and a child is available, the molester will sexually abuse the child. The morally indiscriminate child molester typically uses force, lures, and manipulation to obtain victims. The molester may violently or nonviolently abduct victims. Although most victims are strangers, this type of molester may victimize his or her own children. The morally indiscriminate child molester frequently collects detective magazines or adult pornography of a sadomasochistic nature and may collect child pornography, especially that which depicts prepubescent children. Because this type of molester is an impulsive person who lacks a conscience, he or she is an especially high risk to prepubescent children.

Sexually Indiscriminate Child Molester

The sexually indiscriminate child molester's pattern of behavior is the most difficult to define. Whereas the morally indiscriminate molester is often a sexual experimenter, the sexually indiscriminate molester is discriminating in behavior except when it comes to sex. The sexually indiscriminate child molester will try anything sexual. Much of the molester's behavior is similar to and often confused with that of the preferential child molester. While the sexually indiscriminate molester may have a clearly defined paraphilic or sexual preference—bondage or sadomasochism—he or she has no real sexual preference for children. The molester's basic motivation is sexual experimentation, and he or she appears to have sex with children out of boredom. The molester's main criterion for children is that they are new and different, and he or she involves children in previously existing sexual activity. The indiscriminate child molester may abuse strangers or his or her own children. Although much of the molester's sexual activity with adults may be legal, such an individual may also provide his or her children to other adults as part of group sex, spouse-swapping activities, or bizarre rituals. Of all the situational child molesters, this type of molester is by far the most likely to have multiple victims, to be from a higher socioeconomic background, and to collect pornography and erotica. Child pornography, however, will only be a small portion of the molester's large and varied collection.

Inadequate Child Molester

The inadequate child molester's pattern of behavior is also difficult to define. Such molesters include those suffering from psychoses, eccentric personality disorders, mental retardation, or senility. In layperson's terms, this type of molester is the social misfit, the withdrawn, and the unusual. The molester might be the shy teenager with no friends or the eccentric loner who still lives with his or her parents. Although most such individuals are harmless, some can be child molesters, and in a few cases, child killers. The inadequate child molester typically becomes sexually involved with children out of insecurity or curiosity. Victims are chosen because they are non-threatening objects that allow the molester to explore sexual fantasies. The victim may be a relative, a friend, or a complete stranger. In some cases the child victim might be a specific "stranger" selected as a substitute for a specific adult (possibly a relative of the child) whom the molester is afraid to approach directly. Often the molester's sexual activity with children is the result of built-up impulses. Some of these individuals find it hard to express anger and hostility, which builds until it explodes—possibly against a child victim. Because of mental or emotional problems, some molesters take out their frustrations in cruel sexual torture. The molester's victims could be the elderly as well as children, or anyone who appears helpless at first sight. The inadequate child molester may collect pornography, but it will most likely be of adults.

Almost any child molester is capable of violence or even murder to avoid identification. With a few notable exceptions—Theodore Frank in California and Gary Arthur Bishop in Utah—most of the sexually motivated child murders profiled and assessed by the FBI's Behavioral Science Unit have involved situational child molesters, especially the morally indiscriminate and inadequate patterns of behavior. Low social competence seems to be the most significant factor in why a child molester might abduct a victim.

Preferential Child Molesters

Preferential child molesters have a definite sexual preference for children, and their sexual fantasies and erotic imagery focus on children. They have sex with children not because of some situational stress or insecurity but because they are sexually attracted to and prefer children. They can possess a wide variety of character traits but engage in highly predictable sexual behavior patterns. These patterns are called sexual rituals and are frequently engaged in even when they are counterproductive to getting away

with the criminal activity. Although they may be smaller in number than situational child molesters, preferential child molesters have the potential to molest a larger number of victims. For many of them, their problem is not only one of sex drive (attraction to children), but also quantity (need for frequent and repeated sex with children). They usually have age and gender preferences for their victims. Members of higher socioeconomic groups tend to be over represented among preferential child molesters.

There are three types of preferential child molesters: seductive, introverted, and sadistic.

Seductive Child Molester

The seductive child molester "seduces" children, courting them with attention, affection, and gifts. Over time this behavior gradually reduces the child's sexual inhibitions. Frequently, the victims reach a point where they are willing to trade sex for the attention, affection, and other benefits they receive from the molester. Many seductive child molesters are simultaneously involved with multiple victims, operating what some law enforcement officers call child sex rings (e.g., groups of children in the same school class, neighborhood, day care center, or scout troop). The characteristic that makes the seductive child molester so successful is his or her ability to identify with children. This type of molester knows how to talk to and listen to children. The molester's status and authority as an adult are also an important part of the seduction process. In addition, this type of molester often selects children who are victims of emotional or physical neglect.

The seductive child molester generally prefers victims of a particular sex and age, such as blond, 12-year-old boys, and will seek a new victim when the current victim ages or is no longer considered desirable. Generally the individual's biggest problem is not obtaining child victims but getting rid of a victim when the child becomes too old or unattractive. These offenders may use threats and physical violence to avoid identification and disclosure or to prevent a victim from leaving before the molester is ready to "dump" the victim.

Introverted Child Molester

The introverted child molester has a preference for children but lacks the interpersonal skills necessary to seduce them. Therefore, the molester typically

engages in a minimal amount of verbal communication with the victim and usually victimizes strangers or very young children. In many ways, the introverted child molester fits the old stereotype of the child molester (for example, a man who hangs around playgrounds, exposing himself to children, watching them, or engaging them in brief sexual encounters). The molester may also make obscene phone calls to children. Unable to gain access to children any other way, this molester may use child prostitutes or may even marry and have children, later molesting them as infants. The introverted child molester is similar to the inadequate situational child molester except that he or she has a definite preference for children, and the selection of only children as victims is more predictable.

Sadistic Child Molester

The sadistic child molester not only has a sexual preference for children, but also must inflict physiological or psychological pain on the child in order to achieve sexual arousal. (The molester is aroused by the victim's response to the infliction of pain and suffering.) The sadistic child molester often uses lures or force to gain access to the child and is more likely than the other preferential child molesters to abduct and murder victims. Although there are few sadistic child molesters, they are very dangerous.

Identifying Preferential Child Molesters

Preferential child molesters exhibit several predictable and repetitive behavior patterns that serve as indicators or red flags. If the officer notes that an individual exhibits several of these behaviors, he or she will be able to assess the need for recommending that the individual receive a sex offender evaluation and, possibly, a condition for sex offender treatment. Following are the behavior patterns exhibited by preferential child molesters.

- Long-term and persistent pattern of behavior
  - — *Sexual abuse in the offender's background.* Research indicates that many child molesters were sexually abused as children, although not all sexually abused children grow up to molest children. It is well worth the officer's time and effort to determine if an individual has ever been a victim of sexual abuse and, if so, the nature of the abuse.

- — *Limited social contact during adolescence.* Sexual preference for children usually appears during adolescence, and early pedophiliac behavior may be indicated by a lack of interest in adolescent peers. Like several of these indicators, however, this characteristic alone means little.
- — *Frequent and unexpected moves or premature separation from the military.* When discovered, pedophiles are sometimes asked to leave town in lieu of being prosecuted. It is helpful to look for a pattern of frequent moving or job changes. Frequently there is no formal documentation of what actually happened, so other indicators such as driver's license records can sometimes detect moving patterns. Premature separation from the military with no specific reason given or available may also be a red flag worth noting.
- — *Prior arrests.* Any arrest for child abuse or contributing to the delinquency of a minor is a red flag requiring investigation. However, there might also be other prior arrests not involving sexual abuse that may also be less obvious indicators of pedophilia, such as falsifying a teaching certificate or impersonating a police officer. All arrest records and court documents should be analyzed to determine their significance.
- — *Multiple victims.* The greater the number of victims, the more likely the individual is a pedophile. In addition, if the individual is a known or suspected pedophile, investigate for multiple victims, because there is a high probability that the individual molested more than one child.
- — *Means of obtaining victims.* If the individual used clever and skillful planning to obtain victims or made high-risk attempts to obtain victims, such as snatching a child from a parked car, the chances are high that the individual is a pedophile.

• Children as preferred sexual objects

- — *Is unmarried, lives alone or with parents, or dates infrequently*. By itself, this characteristic means nothing. It only has significance when combined with several other characteristics. Since pedophiles usually have some difficulty performing sexually with adults, they typically do not date, marry, or have a sexual relationship with another adult. They often live alone or with their parents. However, some pedophiles marry to gain access to potential victims.
- — *Has a dysfunctional relationship with spouse.* If a pedophile is married, it is unlikely that he or she has a normal marital relationship with a spouse. Male pedophiles often marry women who are either very strong and domineering or very weak and passive. Because the pedophile is not sexually attracted to his

or her spouse, sexual problems in the marriage are not uncommon. Although they may not readily reveal this information, wives, husbands, ex-spouses, and significant others should be considered important collateral contacts.

— *Associates and circle of friends are young.* Pedophiles frequently socialize with children and get involved in youth activities. Suspicion should be raised when an individual clearly prefers to be around or socialize with young people, tending to hang around the school playground, the neighborhood video arcade, or the shopping center. The individual's friends may be male or female or members of both sexes, and they may be very young or teenagers, all depending on the age and gender preference of the individual.

— *Shows excessive interest in children.* This is not proof that someone is a pedophile, but it is reason to be suspicious. It becomes more significant when this excessive interest is combined with other characteristics.

— *Has limited peer relationships.* Pedophiles cannot share their sexual interests with other adults, so they tend to avoid socializing with peers. The majority of pedophiles only seek the company of other pedophiles in order to validate their lifestyle. If a suspected pedophile has a close adult friend, the possibility that the friend is also a pedophile must be considered.

— *Has an age and gender preference.* Most pedophiles prefer children of a certain sex and age range. The older the age preference, the more exclusive the gender preference. For example, a pedophile attracted to toddlers is likely to molest boys and girls; a pedophile attracted to teenagers is more likely to prefer either boys or girls exclusively. The preferred age bracket for the child may also vary; one pedophile might prefer boys 8 to 12, whereas another might prefer boys 6 to 12. How old a victim looks and acts is more important than actual chronological age. A 13-year-old who looks and acts like a 10-year-old could be the victim of a molester preferring 8- to 10-year-old victims. For the introverted child molester, how old the child looks is more important than how old the child acts. Puberty seems to be an important dividing line for many pedophiles. This is only an age and gender preference, not an exclusive limitation. Any individual expressing a strong desire to adopt or care for a child of a specific age and sex should be viewed with suspicion.

— *Idealizes children.* Pedophiles tend to refer to children in idealistic ways. Frequently they describe children and childhood as clean, pure, or innocent. Sometimes they refer to children as objects, projects, or possessions. For example, a pedophile might say, "I've been working on this project for six months."

- Well-developed techniques to obtain victims
  - *Is skilled at identifying vulnerable children.* Some pedophiles can watch a group of children for a brief period of time and then select a potential victim. More often than not, the victim turns out to be from a broken home or the victim of physical or emotional neglect.
  - *Identifies with children.* Pedophiles usually can identify with children better than they can with adults. This trait makes pedophiles masters of seduction. They know how to talk to children and how to listen to them.
  - *Has access to children.* This is one of the most important indicators of a pedophile. Pedophiles will seek employment and volunteer work that gives them access to children. Examples are teacher, clergymen, police officer, coach, scout leader, Big Brother, or foster parent. The pedophile will also find ways to get the child into a situation where other adults are absent. For example, on a scout trip the pedophile will volunteer to stay with the scouts while the other scout leaders go into town to purchase supplies.
  - *Seduces children.* This is the most common characteristic of pedophiles. They literally seduce children by spending time with them, listening to and paying attention to them, and buying them gifts. As occurs in the courtship process, the victim often develops positive feelings for the molester. This is one reason some children are reluctant to report a molestation.
  - *Manipulates children.* The pedophile uses seduction techniques, competition, peer pressure, child and group psychology, motivation techniques, threats, and blackmail to obtain victims. Part of the manipulation process is the lowering of the child's inhibitions. A skilled pedophile who can get children into a situation in which they must change clothing or stay overnight will almost always succeed in seducing them. However, not all pedophiles possess these skills. The introverted child molester lacks these abilities.
  - *Has toys and playthings.* The pedophile is likely to have toys and playthings at home that appeal to children, such as model boats or planes, dolls, video games, or magic tricks. A pedophile interested in older children may lure victims with pornography, alcohol, or drugs or pretend to have a hobby or interest in things that interest an adolescent, such as stereo equipment or computer games. A house full of children's playthings may indicate pedophilia, particularly if the individual is not a parent; however, this indicator by itself means little. It only has significance when combined with other indicators.

— *Shows sexual materials to children.* Any adult who shows sexually explicit material to children should be viewed with suspicion. This behavior is usually part of the seduction process intended to lower the child's inhibitions. A pedophile may also encourage children to call a dial-a-porn service or send them sexually explicit material via a computer as part of the seduction process.

- Sexual fantasies focusing on children
  — *Has youth-oriented decorations in house or room.* The homes of some pedophiles have been described as shrines to children or as miniature amusement parks. For example, a pedophile attracted to teenage boys might decorate his home the way a teenage boy would with stereos, rock posters, computers, weight equipment, and so on.
  — *Photographs children.* Many pedophiles enjoy taking photographs of their victims, preferably during sexual behavior. Some, however, photograph children fully dressed. For example, a pedophile may go to baseball games or the playground to photograph children. After developing the pictures, the pedophile fantasizes about having sex with the children in the photographs. Such an individual might also frequent youth athletic contests, child beauty pageants, or child exercise classes and photograph them.
  — *Collects child pornography or child erotica.* Most pedophiles collect child pornography. The individual uses the material for sexual arousal and for seducing new victims. An interest in child pornography should always be a red flag indicating possible pedophilia.

    Not to be confused with child pornography, child erotica is any material relating to children that serves a sexual purpose for a given individual. Erotica includes non-pornographic photographs of children, children's clothing, and accessories. Just as pictures of children in underwear or swim wear may be very arousing to the pedophile, combs, barrettes, purses, and other accessories might also be used for sexual arousal. In addition, pedophiles sometimes keep a memento or trophy of their victims, such as a pair of underpants or a lock of hair.

Reactions After Identification

When a child molestation case is uncovered and the individual is identified, there are several predictable reactions by the individual. This is especially true of the preferential child molester. Knowledge of these reactions will help officers investigate the case.

- **Deny the incident.** When a child molester is arrested, his or her first reaction is usually complete denial. The individual will act shocked, surprised, or even indignant about the allegation. The individual may claim to not remember the incident or deny the incident involved sexual gratification. The individual may imply that his or her actions were misunderstood and that a mistake has been made. For example, the individual may state, "I didn't know hugging and kissing my son goodnight was a crime!" Friends and relatives, who may hinder the police investigation or be uncooperative collateral contacts, may aid this denial.
- **Minimize the incident.** If evidence rules out total denial, the individual may minimize the incident, especially in terms of quantity and quality. The individual might claim that it happened once or that he or she only touched or caressed the victim. The individual might admit certain acts, but deny that he or she was engaged in the acts for sexual gratification. For example, the individual may say, "Yeah, I admit I may have fondled my daughter once or twice, but I never had intercourse with her." The daughter explains that in actuality, her father raped her repeatedly over a six-month period. The individual may also admit to lesser offenses or misdemeanors. Victims may sometimes minimize the incident or deny certain aspects of the sexual behavior. For example, many adolescent boys will often deny being victimized.
- **Justify the incident.** Many child molesters, especially preferential child molesters, spend their lives attempting to convince themselves that they are not immoral, sexually deviant, or criminals. They prefer to believe that they are loving individuals whose behavior is misunderstood or politically incorrect at this time in history. Recognizing this rationalization system is key to interviewing these individuals. For example, a pedophile may justify the incident by stating that stress or drinking led to the sexual behavior or by declaring that he or she cares more for the child than the child's parents do. If the individual is the father of the victim, a standard justification is that he is best suited to teach his child about sex. The most common rationalization centers on blaming the victim—the child seduced the individual or initiated the sexual activity, or the child is promiscuous or even a prostitute.
- **Fabricate a reason.** Some of the more clever child molesters come up with ingenious stories to explain their behavior. For example, a doctor may claim to be doing research on pedophilia; a teacher may explain that he or she was providing sex education; a father may claim he slept with his child only because the child had a nightmare and couldn't fall asleep; or a neighbor may claim that neighborhood children made the sexually explicit video, which he kept only to show the children's parents. Some individual s have recently claimed they are

artists victimized by censorship and their pornography collections are works of art protected by the First Amendment. These stories work particularly well when the child molester is a professional, such as a teacher, doctor, or therapist. Law enforcement officials and prosecutors must be prepared to confront such stories and disprove them. Finding child pornography or erotica in the individual's possession is one effective way to do this.

- **Feign mental illness.** The child molester may feign mental illness. It is interesting to note, however, that child molesters will admit mental illness only after they are identified or arrested, or after all other tactics fail. If all pedophiles are not necessarily child molesters, then pedophilia alone cannot be the cause of their child molesting. However, if the behavior of a child molester is considered to be the result of mental illness, then the individual requires treatment. The seriousness of the offenses and the effectiveness of the treatment must be carefully evaluated by the court. Treatment and punishment are not mutually exclusive.
- **Elicit sympathy.** Pedophiles may resort to the "nice guy defense". In this defense, the individual expresses deep regret and attempts to show how he or she is a pillar of the community, a devoted family person, a church leader, a military hero, a nonviolent individual with no prior arrests, or a victim whose many personal problems led to some sort of breakdown. Many traits described by the individual as evidence of good character in fact contribute to the individual's ability to access and seduce children.
- **Attack.** The identified pedophile may become threatening and assaultive during the investigation or prosecution. This reaction consists of attacking or going on the offensive. For example, the individual may harass, threaten, or bribe witnesses and victims, attack the reputation and personal life of the officer or prosecuting attorney, raise issues such as gay rights if the victim is the same sex as the individual, or enlist the support of groups or organizations. In extreme cases violence is a possibility. Pedophiles have been known to murder their victims or witnesses to avoid identification and prosecution.
- **Plead guilty, but not guilty.** Some individual s will try to make a deal to avoid a public trial. Although this results in the highly desirable objective of avoiding child victim testimony, the unfortunate aspect of this situation is that the individual is often allowed to plead, in essence, "guilty, but not guilty". This sometimes involves a plea of *nolo contendere* to avoid civil liability. On other occasions the individual pleads not guilty by reason of insanity or agrees to plead guilty to less severe charges, such as contributing to the delinquency of a minor, lewd and lascivious conduct, or indecent liberties. These are all tactics to escape

prosecution, keep the public from fully understanding the arrest or charge, and prevent the pedophile from acknowledging his or her behavior.

- **Commit suicide.** This extreme reaction is possible for some pedophiles, especially middle-class individual s with no prior convictions. Arrest or conviction may cost them their job, family, or reputation, leading to severe depression and possibly suicide.

Appendix A: Frequently Encountered Terminology[7]

affect—a pattern of observable behaviors that express a subjectively experienced feeling state, or emotion, such as euphoria, anger, or sadness. Types of affect may be described as broad (normal), restricted (a limited number of feeling states), blunted (reduced intensity of emotion), flat (lacks emotion), or inappropriate (emotion and content of conversation do not match).

affective disorder—a disorder in which mood change or disturbance is the primary symptom.

agoraphobia—a fear of being in places or situations from which escape might be difficult or embarrassing or in which help might not be available if needed. According to *DSM-IV*, it is frequently associated with panic disorder.

alcohol abuse—use of alcohol to the point that the individual's physical, mental, emotional, or social well-being is impaired.

antidepressant medication—medication prescribed to treat the symptoms of depression. Some antidepressant drugs are used to treat obsessive-compulsive disorders and other disorders as well.

antimanic medication—medication prescribed to treat the symptoms associated with a manic episode or bipolar disorder. Also referred to as "mood levelers" or "mood-stabilizing drugs."

antipsychotic medication—medication prescribed to treat the symptoms of schizophrenia and other disorders involving psychotic symptoms. Such drugs are often more effective at controlling certain symptoms than at "curing" the disorder.

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7. Developed for the Federal Judicial Center by Dr. Melissa Cahill, Chief Psychologist, Dallas County Community Supervision and Corrections Department, Dallas, Tex. Sources include the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., rev. 2000); Evelyn M. Stone, *American Psychiatric Glossary*. 6th ed. Washington, D.C.: APA, 1988, 1–75; memorandum from L. Ralph Mecham to all chief judges, chief probation officers, and chief pretrial services officers: "Reimbursement/Copayment for Treatment Services—Information," March 22, 1993; "The Americans with Disabilities Act: Impact on Training," *Info-Line* 9203 (March 1992), 10–11.

antisocial personality disorder—a disorder characterized by an inability to conform to social norms and a continuous display of irresponsible and antisocial behavior that violates the rights of others. A diagnosis of this disorder can only be made after age 18 and must include evidence of antisocial conduct with an onset prior to age 15.

anxiety—apprehension, tension, or uneasiness that stems from the anticipation of danger without an identifiable source.

anxiety disorder—a disorder in which anxiety is the most prominent symptom. Anxiety disorders include panic disorder, phobias, obsessive-compulsive disorder, and post-traumatic stress disorder.

avoidant personality disorder—a pervasive pattern of social discomfort, fear of negative evaluation, and timidity beginning by early adulthood and present in a variety of contexts.

Axes I, II, III, IV, and V—*DSM-IV* divides disorders into five diagnostic classes or axes: Axis I: clinical disorders including major psychiatric disorders; Axis II: personality disorders and mental retardation; Axis III: general medical conditions; Axis IV: psychosocial and environmental problems; and Axis V: global assessment and highest level of adaptive functioning.

behavior therapy—a mode of treatment that focuses on modifying an individual's observable behavior by manipulating the environment, dysfunctional behavior, or both.

bipolar disorder—a disorder in which there are episodes of mania, alone or with depression; sometimes referred to as manic-depressive illness.

borderline personality disorder—a disorder characterized by a pattern of extremely unstable mood, self-image, and relationships that begins by early adulthood and is present in a variety of contexts.

child molester—an individual who sexually abuses children. A child molester may or may not be a pedophile.

claustrophobia—a type of phobia in which the individual has a fear of closed spaces.

compulsion—repetitive, purposeful, and intentional behaviors that are performed in response to an obsession, according to certain rules, or in a stereotyped fashion. Failure to perform such behaviors may lead to overt anxiety.

co-occurring disorder—term used to describe an individual with an Axis I disorder and a substance abuse or alcohol problem.

cyclothymia—a chronic mood disturbance of at least two years' duration, involving numerous episodes of mania or depression that are not severe enough to be diagnosed as major depression or bipolar disorder. Some researchers feel cyclothymia is a mild form of bipolar disorder.

decompensation—the deterioration of defense mechanisms, leading to an intensification of the disorder.

defense mechanisms—unconscious processes that serve to provide relief from emotional conflict and anxiety. Some common defense mechanisms are dissociation, idealization, and denial.

delirium—an acute organic mental disorder characterized by confusion and altered, possibly fluctuating, consciousness owing to an alteration of cerebral metabolism. It may include delusions, illusions, and hallucinations.

delusions—false beliefs based on incorrect inferences about external reality. These beliefs are firmly held in spite of what almost everyone else believes and in spite of proof or evidence to the contrary.

dementia—an organic mental disorder in which an individual's previously acquired intellectual abilities deteriorate to the point that social or occupational functioning is impaired.

denial—a defense mechanism, operating unconsciously, that enables an individual to disavow thoughts, feelings, wishes, needs, or external reality factors that are consciously intolerable.

dependent personality disorder—a pervasive pattern of dependence and submission beginning by early adulthood and present in a variety of contexts.

depersonalization—an altered perception or experience of the self in which an individual's own reality is temporarily lost. This is manifested in a sense of self-estrangement or unreality, which may include the feeling that one's extremities have changed in size or a sense of perceiving oneself from a distance (usually from above).

depression—when used to describe mood, depression refers to feelings of sadness, despair, and discouragement. As such, depression may be a normal feeling state. Depression is also a symptom of a variety of mental or physical disorders. Depression that results in a depressive episode can be classified as a mental disorder. The *DSM-IV* defines a depressive episode as a sustained period (at least two weeks) during which an individual experiences depression and all associated features of depression or a loss of interest or pleasure in most or all activities.

derealization—a feeling of detachment from one's environment.

devaluation—a defense mechanism in which an individual attributes overly negative qualities to oneself or others.

diagnosis—a mental health treatment provider's professional determination that an individual has a mental disorder based on a professional analysis of the individual's behavior and the diagnostic classifications in *DSM-IV*.

Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR)—the fourth revised edition of the American Psychiatric Association publication used by mental health professionals to diagnose mental disorders. *DSM-IV-TR* does not generally address the causes or different theories for a psychiatric disorder, but defines mental disorders in terms of descriptive symptoms and behaviors.

dissociation—the splitting off of clusters of mental contents from conscious awareness, a mechanism central to hysterical conversion and dissociative disorders; the separation of an idea from its emotional significance and affect as seen in the inappropriate affect of patients with schizophrenia.

drug interaction—the effects of two or more drugs or medications taken simultaneously, which differ from the usual effects of either drug or medication taken alone.

dual diagnosis—a diagnosis given to individuals with both mental retardation and an Axis I disorder.

dysthymia—a chronic disturbance of mood lasting at least two years and involving depressed mood and other associated symptoms of depression. The symptoms of depression are not severe enough to warrant a diagnosis of major depression.

enabler—someone who helps a mentally disordered or substance-abusing individual avoid crises and the consequences of his or her behavior.

etiology—the cause or origin of a disease or disorder as determined by medical or psychiatric diagnosis.

family therapy—psychotherapy of more than one member of a family in the same session. The assumption is that a mental disorder in one member of the family may be sustained and exacerbated by interaction patterns within the family.

flight of ideas—a nearly continuous flow of accelerated speech with abrupt changes from topic to topic, usually based on understandable associations, distracting stimuli, or plays on words. When the condition is severe, speech may be disorganized and incoherent.

grandiosity—an inflated appraisal of one's worth, power, knowledge, importance, or identity.

group therapy—a form of psychotherapy in which the interaction of a group of patients helps to modify the behavior of individual patients in the group.

hallucination—a sensory perception in the absence of external stimuli; may occur in any of the senses.

hallucination, auditory—a hallucination of sound, most commonly of voices but sometimes of clicks, rushing noises, or music.

hallucination, visual—a hallucination of formed images, such as people, or of unformed images, such as flashes of light.

histrionic personality disorder—a pervasive pattern of colorful, dramatic, extroverted behavior accompanied by excessive emotionality and attention-seeking that begins by early adulthood and is present in a variety of contexts.

hypersomnia—a behavior involving excessive amounts of sleep, sometimes associated with confusion upon waking. Hypersomnia may involve sleeping for a longer amount of time than usual, experiencing daytime sleepiness, or taking excessive naps.

hypervigilance—behavior involving excessive alertness and watchfulness.

idealization—a defense mechanism in which an individual attributes overly positive qualities to oneself or to others.

ideas of reference—ideas, held less firmly than delusions, that events, objects, or other people in the individual's immediate environment have a particular and unusual meaning for him or her.

ideation—the forming of a mental image or an idea or concept.

incoherence—speech that, for the most part, is not understandable because of a lack of logical or meaningful connection between words, phrases, or sentences; excessive use of incomplete sentences; excessive irrelevancies or abrupt changes in subject matter; idiosyncratic word usage; or distorted grammar.

insomnia—inability to fall asleep or stay asleep, or early morning waking.

local study—a court-ordered evaluation undertaken to assess an individual's mental health in order to determine sentencing. Local studies are conducted by a community mental health treatment provider or by the Bureau of Prisons if the court feels there is a compelling reason the evaluation cannot be done by a community provider.

loosening of associations—thinking characterized by speech in which ideas shift from one subject to another without the speaker showing any awareness that the topics are unconnected or only obliquely related to one another.

magical thinking—a conviction that thinking creates action or circumstances. It occurs in dreams, in children, in primitive peoples, and in patients under a variety of conditions. It is characterized by lack of a realistic understanding of the relationship between cause and effect.

major depression—a disorder in which there is a history of episodes of depressed mood or a loss of pleasure in most or all activities.

mania—a disorder characterized by excessive elation, hyperactivity, agitation, and accelerated thinking and speaking. Mania is associated with Axis I mood disorders and certain organic mental disorders.

manic-depressive illness—a disorder characterized by periods of both mania and depression. Also called bipolar disorder.

mental disorder—an illness with psychological or behavioral manifestations and/or impairment in functioning that is due to a social, psychological, genetic, physical-chemical, or biological disturbance. The illness is characterized by symptoms, impairment in functioning, or both.

mental health treatment provider—any treatment source that provides treatment services to individuals with mental disorders. The provider may be under contract to the Administrative Office of the U.S. Courts.

mental retardation—significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and first manifested during childhood.

multiple diagnoses—a term used to describe an individual diagnosed with more than one Axis I disorder or Axis II disorder or both an Axis I disorder and an Axis II disorder (e.g., major depression and borderline personality disorder).

multiple personalities—an extreme form of dissociation in which an individual's personality is split into two or (usually) more distinct personalities, often alternating with one another. This condition is rare.

narcissistic personality disorder—a heightened sense of grandiosity, hypersensitivity to evaluation by others, and lack of empathy for others beginning by early adulthood and present in a variety of contexts.

obsessions—persistent ideas, thoughts, impulses, and images that invade the consciousness and are intrusive, senseless, or repugnant, such as thoughts of violence, fears of contamination, or feelings of doubt.

obsessive-compulsive disorder—recurrent obsessions or compulsions that are distressful and time-consuming and significantly interfere with the individual's occupational and social functioning.

obsessive-compulsive personality disorder—a disorder characterized by restricted emotions, orderliness, indecisiveness, perfectionism, and inflexibility that begins by early adulthood and is present in a variety of contexts.

organic mental disorder—a transient or permanent dysfunction of the brain caused by a disturbance of physiological functioning of brain tissue. Causes are associated with aging, toxic substances, and a variety of physical disorders.

panic—sudden, overwhelming anxiety of such intensity that it produces terror and physiological changes.

panic attack—discrete periods of intense fear or discomfort, often associated with feelings of impending doom.

panic disorder—an anxiety disorder, with or without agoraphobia, that includes recurrent panic attacks accompanied by various physical symptoms.

paranoid—a term commonly used to describe an overly suspicious person. In technical use, the term refers to a type of schizophrenia or a class of delusional disorders.

paranoid personality disorder—a pervasive and unwarranted tendency to interpret the actions of others as deliberately threatening and demeaning. This disorder begins by early adulthood and is present in a variety of contexts.

paraphilia—a condition in which persistent and sexually arousing fantasies of an unusual nature are associated with preference for or use of a nonhuman object, sexual activity with human beings involving real or simulated suffering or humiliation, or sexual activity with children or non-consenting partners.

pedophile—an individual whose sexual fantasies, urges, and behavior involve sexual activity with prepubescent children.

pedophilia—intense sexual urges and sexual fantasies involving sexual activity with a child.

personality—deeply ingrained patterns of behavior, thinking, and feeling that an individual develops, both consciously and unconsciously, as a style of life or a way of adapting to the environment.

personality disorder—pervasive, inflexible, and maladaptive patterns of behavior and character that are severe enough to cause either significant impairment in adaptive functioning or subjective distress. Personality disorders are generally recognizable by adolescence or earlier and continue throughout adulthood.

phobia—a persistent, irrational fear of, and compelling desire to avoid, a specific object, activity, or situation.

pornography—sexually explicit reading or video material or photographs.

post-traumatic stress disorder (PTSD)—a disorder that develops after the person has experienced, witnessed, or was confronted with an event that involved actual or threatened death or serious injury or that threatened the physical integrity of the individual or others (e.g., military combat, rape, child abuse).

poverty of speech—a restriction in the amount of speech such that spontaneous speech and replies to questions are brief and unelaborated.

prodromal—having to do with early signs or symptoms of a disorder.

prognosis—a professional opinion concerning the probable treatment success and recovery of an individual with a diagnosed mental disorder.

psychiatrist—a licensed physician who specializes in diagnosing, treating, and preventing mental disorders. A psychiatrist must have a medical degree and four years or more of approved postgraduate training.

psychomotor agitation—generalized physical and emotional overactivity in response to internal stimuli or external stimuli or both.

psychomotor retardation—generalized slowing of physical and emotional reactions.

psychosis—a major mental disorder of organic or emotional origin in which a person's ability to think, respond emotionally, remember, communicate, interpret reality, and behave appropriately is impaired so as to interfere grossly with the capacity to meet the ordinary demands of life. The term is applicable to conditions with a wide range of severity and duration, such as schizophrenia, bipolar disorder, depression, and organic mental disorder.

psychosocial—involving aspects of both psychological and social behavior.

psychotherapist—a person trained to treat mental disorders.

psychotherapy—the treatment of mental disorders through the uncovering of unconscious conflict and its resolution. Psychotherapy may be conducted with individuals, couples, family members, or groups.

psychotic episode—an episode that occurs when a mentally disordered individual incorrectly evaluates the accuracy of his or her perceptions, thoughts, and moods and makes incorrect inferences about external reality. During a psychotic episode an individual's ability to think, respond emotionally, remember, communicate, interpret reality, and behave appropriately is impaired.

rationalization—a defense mechanism in which the person devises reassuring or self-serving, but incorrect, explanations for his or her own behavior and the behavior of others.

reality testing—the objective evaluation and judgment of the world outside oneself.

residuals—the phases of illness during which the person is not exhibiting the symptoms.

ruminate—to excessively reflect or meditate on an issue, thought, or concept.

schizoid personality disorder—a lifelong pattern of social withdrawal beginning by early adulthood and present in a variety of contexts.

schizophrenia—a group of disorders manifested by disturbances in communication, language, thought, perception, affect, and behavior which last longer than six months.

schizotypal personality disorder—a pervasive pattern of peculiarities of ideation, appearance, and behavior beginning by early adulthood and present in a variety of contexts.

somatization—a defense mechanism in which the individual becomes preoccupied with physical symptoms disproportionate to any actual physical illness or injury.

stereotypy—persistent, mechanical repetition of speech or movements observed in individuals with schizophrenia.

syndrome—a group of symptoms that occur together and constitute a recognizable condition.

treatment plan—a strategy for treating the symptoms of a mental disorder or curing the disorder. Treatment plans are developed by mental health professionals and usually consist of therapy and, if required, medication.

Appendix B: *DMS-IV* Classification Axes

This appendix provides an overview of the *DSM-IV* classification system, including a description of the Global Assessment of Functioning (GAF) and Social and Occupational Functioning Assessment Scale (SOFAS).

DSM-IV Classification Axes

Axis I	Clinical syndromes and V codes: V codes are other conditions that are a focus of clinical attention for which there is insufficient information to know whether or not a presenting problem is attributable to a mental disorder
Axis II	Personality disorders and mental retardation
Axis III	General medical conditions that are relevant to etiology or case management
Axis IV	Psychosocial and environmental problems
Axis V	Global Assessment of Functioning (GAF) scale

Example of a *DSM-IV* Multiaxial Evaluation

Axis I	Major depression disorder, single episode, severe without psychotic features; alcohol abuse
Axis II	Dependent personality disorder; frequent use of denial
Axis III	None
Axis IV	Threat of job loss
Axis V	GAF = 35 (current)

Codes for Axis V: GAF Scale

Axis V is for reporting the clinician's judgment of the individual's overall level of functioning. This information is useful in planning treatment and measuring its impact, and in predicting outcome. The GAF scale may be particularly useful in tracking the clinical progress of individuals in global terms, using a single measure. The scale is used with respect only to psychological, social, and occupational functioning. It does not include impairment in functioning due to physical or environmental limitations.

Code (*Note*: The GAF scale is a continuum of mental health and mental disorders. Intermediate codes can be used when appropriate, e.g., 45, 68, 72.)

91–100 There is superior functioning in a wide range of activities; life's problems never seem to get out of hand; individual is sought out by others because of his or her many positive qualities. No symptoms.

81–90 Symptoms are absent or minimal (e.g., mild anxiety before an exam); there is good functioning in all areas; individual is interested and involved in a wide range of activities, socially effective, and generally satisfied with life, and has no more than everyday problems or concerns (e.g., an occasional argument with family members).

71–80 If symptoms are present, they are transient and expectable reactions to psychosocial stressors (e.g., difficulty concentrating after family argument); individual has no more than slight impairment in social, occupational, or school functioning (e.g., temporarily falling behind in schoolwork).

61–70 Some mild symptoms are present (e.g. depressed mood and mild insomnia), or there is some difficulty in social, occupational, or school functioning (e.g. occasional truancy, or theft within the household), but generally individual is functioning pretty well and has some meaningful interpersonal relationships.

51–60 Moderate symptoms are present (e.g., flat affect and circumstantial speech, occasional panic attacks), or there is moderate difficulty in social, occupational, or school functioning (e.g., individual has few friends, conflicts with peers or co-workers).

41-50 Serious symptoms are present (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting), or there is serious impairment in social, occupational, or school functioning (e.g., individual has no friends, is unable to keep a job).

31–40 Some impairment in reality testing or communication is present (e.g., speech at times is illogical, obscure, or irrelevant), or there is major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood (e.g., depressed man avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school).

21–30 Behavior is considerably influenced by delusions or hallucinations, or there is serious impairment in communication or judgment (e.g., individual sometimes is incoherent, acts grossly inappropriately, has suicidal preoccupations) or individual is unable to function in almost all areas (e.g., stays in bed all day; no job, home, or friends).

11–20 There is some danger that individual may hurt himself or herself or others (e.g., individual attempts suicide without clear expectation of death; is frequently violent; exhibits manic excitement); or individual occasionally fails to maintain minimal personal hygiene (e.g., smears feces), or there is gross impairment in communication (e.g., largely incoherent or mute).

1–10 There is a persistent danger that individual will severely hurt himself or herself or others (e.g., there have been instances of recurrent violence), or individual exhibits a persistent inability to maintain minimal personal hygiene or serious suicidal act with a clear expectation of death.

0 Inadequate information.

Social and Occupational Functioning Assessment Scale (SOFAS)

SOFAS is a new scale that differs from the GAF scale in that it focuses exclusively on the individual's level of social and occupational functioning and is not directly influenced by the overall severity of the individual's psychological symptoms. Also in contrast to the GAF scale, any impairment in social and occupational functioning that is due to general medical conditions is considered in making the SOFAS rating. SOFAS is usually used to rate functioning for the current period (i.e., the level of functioning at the time of the evaluation), and may also be used to rate functioning for the past year (i.e., the highest level of functioning for at least a few months during the past year).

To be counted, impairment must be a direct consequence of mental and physical health problems; the effects of lack of opportunity and other environmental limitations are not to be considered.

Code (*Note:* Intermediate codes may be used when appropriate, e.g., 45, 68, 72.)

91–100 Superior functioning in a wide range of activities

81–90 Good functioning in all areas; occupational and social effectiveness

71–80 No more than a slight impairment in social, occupational, or school functioning (e.g., infrequent interpersonal conflict, temporary falling behind in schoolwork)

61–70 Some difficulty in social, occupational, or school functioning, but generally good functioning well, some meaningful interpersonal relationships

51–60 Moderate difficulty in social, occupational, or school functioning (e.g., individual has few friends, conflicts with peers or co-workers)

41-50 Serious impairment in social, occupational, or school functioning (e.g., individual has no friends, is unable to keep a job)

31–40 Major impairment in several areas, such as work or school, family relations (e.g., depressed man avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home and failing at school)

21–30 Inability to function in almost all areas (e.g., individual stays in bed all day, has no job, home, or friends).

11–20 Occasional failure to maintain minimal personal hygiene; inability to function independently

1–10 Persistent inability to maintain minimal personal hygiene; inability to function without harming self or others or without considerable external support (e.g., nursing care and supervision)

0 Inadequate information

Appendix C: Antipsychotic Medications

The chart below lists commonly prescribed antipsychotic medications.[8]

Generic Name	Brand Name	Dosage Range[1]	Sedation	EPS[2]	ACH Effects[3]	Equivalence[4]
Low Potency						
chlorpromazine	Thorazine	50-1500 mg	high	++	++++	100 mg
thioridazine	Mellaril	150-800 mg	high	+	+++++	100 mg
clozapine	Clozaril	300-900 mg	high	0	+++++	50 mg
mesoridazine	Serentil	50-500 mg	high	+	+++++	50 mg
quetiapine	Seroquel	150-400 mg	mid	+/0	+	50 mg
High Potency						
molindone	Moban	20-225 mg	low	+++	+++	10 mg
perphenazine	Trilafon	8-60 mg	mid	++++	++	10 mg
loxapine	Loxitane	50-250 mg	low	+++	++	10 mg
trifluoperazine	Stelazine	10-40 mg	low	++++	++	5 mg
fluphenazine	Prolixin[5]	3-45	low	+++++	++	2 mg
thiothixene	Navane	10-60 mg	low	++++	++	5 mg
haloperidol	Haldol[5]	2-40 mg	low	+++++	+	2 mg
pimozide	Orap	1-10 mg	low	+++++	+	1-2 mg
risperidone	Risperdal	4-16 mg	low	+	+	1-2 mg
olanzapine	Zyprexa	5-20 mg	mid	+/0	+	1-2 mg
ziprasidone	Geodon	60-160 mg	low	+/0	++	10 mg

1. Usual daily oral dosage.
2. Acute: Parkinson's, dystonias, akathisia. Does not reflect risk for tardive dyskinesia. All neuroleptics may cause tardive dyskinesia, except clozapine.
3. Anticholionergic side effects.
4. Dose required to achieve efficacy of 100 mg chlorpromazine.
5. Available in time-release IM format.

8. Identified as free download at Web Site www.PsyD-fx.com. (October 2003).

Appendix D: National Associations, Agencies, and Clearinghouses

The organizations listed below provide information, research, or educational materials on mental disorders. Addresses and telephone numbers are current as of August 2003.

American Psychiatric Association (APA)
1000 Wilson Boulevard, Suite 1825
Arlington, VA 22209-3901
(703) 907-7300

Anxiety Disorders Association of America
8730 Georgia Avenue, Suite 600
Silver Spring, MD 20910
(240) 485-1001

Bureau of Justice Assistance Clearinghouse
Box 6000
Rockville, MD 40849-6000
(800) 688-4252

National Alliance for the Mentally Ill (NAMI)
2107 Wilson Boulevard, Suite 300
Arlington, VA 22201-3042
(703) 524-7600 (Main office number)
(800) 950-6264 (Helpline)

National Association of State Mental Health Program Directors
66 Canal Center Plaza, Suite 302
Alexandria, VA 22314-1591
(703) 739-9333

National Council for Community Behavioral Health Care
12300 Twinbrook Parkway
Suite 320
Rockville, MD 20852
(301) 984-6200
(Publishes the *National Registry of Community Mental Health Services*, a directory of community mental health centers in each state.)

Depression and Related Affective Disorders Association (DRADA)
Johns Hopkins Hospital
600 North Wolfe Street
Baltimore, MD 21287-7381
(410) 583-2919

National Institute of Corrections (NIC) Information Center
1860 Industrial Circle, Suite A
Longmont, CO 80501
(303) 682-0213

National Institute of Justice Clearinghouse
P.O. Box 6000
Rockville, MD 20849-6000
(800) 851-3420

National Institute of Mental Health
Information Resources and Inquiries Branch
Office of Scientific Information
5600 Fishers Lane
Room 7C-02
Rockville, MD 20857
(301) 443-4513

National Depressive and Manic Depressive Association
730 North Franklin Street, Suite 501
Chicago, IL 60610
(312) 642-0049

National Mental Health Association (NMHA)
2001 North Beauregard Street, 12th Floor
Alexandria, VA 22311
(703) 684-7722 (Main office number)
(800) 969-6642 (Information Center)

National Rural Health Association
1 West Armour Boulevard,
Suite 203
Kansas City, MO 64111
(816) 756-3140

Appendix E: Related Web Sites

J-Net Resource

http://jnet/courtoperations/fcsd/html/mentalhealth/policy.htm – Office of Probation and Pretrial Services of the Administrative Office of the U.S. Courts
Offers a mental health and substance abuse page designed to support officers and staff in their work with individuals with mental disorders by providing resources such as

- a collection of better practices and innovative programs to consider relating to mental health and substance abuse;
- a collection of frequently asked questions pertaining to mental health, substance abuse, and contract administration;
- policies and procedures documents;
- a monthly "ask the expert" column;
- a page of links to other mental health resources Web sites; and
- a national directory of probation and pretrial services officers, including contract administrators and intensive supervision specialists working with mental health and sex offender cases.

Nonprofit Organizations

www.nami.org – National Alliance for the Mentally Ill
Information on local support groups, educational programs, advocacy, and research.

www.narsad.org – National Alliance for Research on Schizophrenia and Depression
Information about research on mental illness.

www.ndmda.org – National Depressive and Manic Depressive Association (now called DBSA, Depression and Bipolar Support Alliance)
Information on mood disorders, support groups, and other resources.

www.nmha.org – National Mental Health Association
Information about mental illness, advocacy, etc.

www.bazelon.org – Bazelon Center for Mental Health Law
Information about current legislative issues, including legal cases, criminalization of the mentally ill, and managed care.

Federal Government Sites

www.nimh.nih.gov – National Institute of Mental Health

www.mentalhealth.org - Substance Abuse and Mental Health Services Administration's National Mental Health Information Center.

Professional Organizations

www.apa.org - American Psychological Association

www.psych.org - American Psychiatric Association

www.naswdc.org - National Association of Social Workers

Other

www.schizophrenia.com
Information on schizophrenia, chat rooms, etc.

www.well-connected.com
Health site that gives information on all health issues, including mental illness, and free reports and quarterly highlights. E-mail: bppad@yahoo.

Appendix F: Commonly Used Abbreviations

Professional Degrees and Licenses

BSW. - Bachelor of Social Work
MA - Master of Arts
MS- Master of Science
MSW - Master of Social Work
PsyD - Doctor of Psychology
PhD - Doctor of Philosophy
MD - Doctor of Medicine
NP - Nurse Practitioner
CSW - Clinical or Certified Social Worker
LCDC - Licensed Chemical Dependency Counselor
LMSW - Licensed Master Social Worker
LMSW-ACP - Licensed Master Social Worker - Advanced Clinical Practitioner
LPC - Licensed Professional Counselor

Diagnoses and Conditions

BP - blood pressure
CVA - cerebral vascular accident
CHI - closed head injury
DM - diabetes mellitus
ED - emotionally disturbed
h/a - headache
H/A - heart attack
GSW - gunshot wound
LD - learning disabled
MVA - motor vehicle accident
sz - seizures

Treatment

AMA - against medical advice

d/c - discharge or discontinue

Dx - diagnosis

H/o - history of

Hx - history

Rx/Tx - treatment

Sx - symptoms

WNL - within normal limits

Provisional – not certain if person meets criteria for diagnosis

Personality disorder NOS – not otherwise specified, symptoms that do not meet the criteria for a specific personality disorder

Shorthand

@ - at or about

c - with

s - without

w/i - within

w/o - without

? - change

a - before

p - after

s/p - status post, which means after something (e.g., s/p GSW mean status post gunshot wound)

↑ - increase

↓ - decrease

NS - no show

w/d - withdrawal

RTC - return to clinic

RTW - return to work

D/O - disorder

R/O – rule out

TP - treatment plan

MDT - multidisciplinary team